

Navy–NGO Coordination for Health-Related HCA Missions: A Suggested Planning Framework

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A handwritten signature in dark ink, reading "Eric W. Christensen". The signature is fluid and cursive, with the first name "Eric" and last name "Christensen" clearly legible, and "W." in the middle.

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Executive summary

Humanitarian and civic assistance (HCA) missions are military missions that deliver medical, dental, and other services to underserved populations in developing countries. HCA missions are deliberately planned and conducted in noncrisis environments. The current National Security and National Defense Strategies identify HCA missions as an important part of our Nation's efforts to promote peace and stability throughout the world.

Emphasizing the importance of unity of effort among all actors in an area of operations, guidance from the Department of Defense (DOD) and the Office of the Chief of Naval Operations also identifies working with U.S. and foreign nongovernmental organizations (NGOs) as a key means to deliver HCA. The guidance acknowledges that NGOs have local knowledge and special expertise that can contribute to HCA missions.

There is limited doctrine, however, on how to work with NGOs in the HCA setting. As a result, there is currently no systematic framework for military-NGO coordination. The geographic combatant commanders (COCOMs) are left to determine when it is appropriate to include NGOs, how to identify the appropriate NGOs with which to work, and how to include them in the practical aspects of the mission.

As a force provider, the Bureau of Navy Medicine (BUMED) is focused on planning for and providing necessary resources to support the COCOMs as they conduct HCA missions around the world. To inform policies for planning and manning such missions, BUMED's Deputy Chief of Staff, Future Plans and Strategy (M5) asked the Center for Naval Analyses (CNA) to investigate how to best work with NGOs to deliver effective sea-based health-related HCA (HRHCA). In particular, we were asked to identify key NGO resources and ways to leverage them, as well as barriers that prohibit

or inhibit NGOs from working with the Navy and ways to eliminate or overcome them.

Because the primary audience for this report is the study sponsor (M5) and other Navy commands, the report is generally written from a Navy-centric perspective. The secondary audience is the broader DOD community, while potential readers outside DOD, such as those from other government agencies and NGOs, make up a tertiary audience. The issues are framed in a way that reflects the Navy's current views and thinking, but NGO perspectives are introduced at key points, particularly when differences in perspectives constitute barriers to the development of working relationships. Despite the Navy-centric perspective, the operating assumption is that Navy-NGO coordination should only occur in the form of mutually beneficial working relationships between equal actors.

Approach

Our investigation was guided by the following logical construct:

- Navy-NGO coordination should be driven by strategic considerations for both parties.
- From the Navy's perspective, the objectives of HRHCA missions should inform the reasons for seeking to work with NGOs.
- The reasons for working with NGOs should inform the Navy's thinking about how, when, and with what types of NGOs it can most productively coordinate.
- The types of NGOs and the nature of the coordination then define the barriers that arise when trying to create effective working teams from members of organizations with different cultures and potentially different missions.

The research and analysis presented in this report derives from a three-pronged data collection effort. It is based on the collection and synthesis of information and perspectives from three general sources: written and online documents and articles, informal inter-

views and conference participation, and comments from an external review panel.

Summary of findings

Previous HRHCA missions

We examined three previous HRHCA missions—the 2006 and 2007 deployments of USNS *Mercy*, USNS *Comfort*, and USS *Peleliu*—looking at how they were planned and executed relative to the guidance. We also assessed the nature of the Navy-NGO coordination.

Our review of the assessments of these missions indicates that the high-level guidance has not yet been translated into an accepted set of procedures either for conducting sea-based HRHCA in general or for working with NGOs on HRHCA missions. This lack of procedure is reflected in the ad hoc approach to planning, executing, and assessing each of the three missions.

For example, our research indicated that there is neither a formal military manning requirement for sea-based HRHCA missions nor an approved process for manning the missions. Each of the previous missions was manned differently. The mission manning requirement and process affect the way in which the Navy plans for and incorporates NGOs in HRHCA missions and define the barriers to cooperation. The ad hoc approach to the mission planning in general led to an ad hoc approach to incorporating NGOs. This lack of manning procedure has resulted in an emphasis on gaining access to NGO medical personnel to replace Navy medical personnel, rather than gaining access to their institutional expertise and experience.

In addition, there are not yet established metrics for assessing the success of HRHCA missions. Mission planners, CNA, and other research institutions are using a variety of methods to assess the extent to which some of the strategic objectives are being achieved and to capture operational and tactical data and lessons learned. There is no process for linking operational success or failure to strategic success or failure.

The successful coordination with NGOs was an objective in all three missions, but the approaches to incorporating personnel were ad hoc and not tied directly to either capability requirements for the missions or to the mission's strategic objectives. Making NGO integration an objective in and of itself has emphasized operational processes for including NGOs as ship-riders rather than ways to create synergies with a broader range of NGOs to achieve both operational objectives and strategic goals.

How the Navy can leverage NGO resources

Two primary objectives of HRHCA missions are to provide medical and dental care and public health services and to train military members for disaster response. From the Navy's perspective, the objectives of the mission should inform the reasons for seeking to work with NGOs. Specifically, NGOs have resources that, when combined with Navy resources, can improve the effectiveness of HRHCA missions. These synergistic resources are manpower, experience, and expertise.

Manpower is the first NGO resource that the Navy may seek to leverage. Our research and analysis revealed three potential models for incorporating NGO personnel into Navy HRHCA missions. In the first model, NGO personnel could *augment* military personnel, so that more or different services could be provided with the same number of military personnel. In the second model, NGO personnel could *decrement* military personnel, so that the same services could be provided with fewer military personnel on a given mission. In the third model, NGO personnel could *offset* military personnel, so that the same services could be provided and the total military personnel requirement is systematically reduced.

Expertise is the second NGO resource that the Navy may seek to leverage. As currently staffed, the Navy may not have the expertise necessary to address every facet of an HRHCA mission. NGOs have expertise in two key areas for HRHCA missions: specialized medicine and disaster response. Expertise in both areas contributes to both mission objectives by providing quality medical care and facilitating training for Navy and NGO cooperation in disaster response.

Experience is the third NGO resource that the Navy may seek to leverage for HRHCA missions. Specifically, NGOs have valuable local knowledge and professional networks that can help the military improve its operational access to remote areas and high-need populations. In addition, NGOs have experience in capacity-building activities in the health care sector that can help decrease the likelihood that the missions have unintended negative consequences and increase the likelihood that they have longer term positive effects.

We identified four potential ways that NGOs can participate in the mission:

1. Assist with all phases of mission planning, including project and site selection, needs assessment, and patient selection and screening.
2. Embark on the ship and provide medical care afloat and ashore.
3. Assist with onshore delivery of medical/dental care and public health services.
4. Help with followup care after the site visit (or mission).

Navy-NGO coordination procedures should include explicit identification of the NGO resources that will be most valuable on the mission and how NGOs can make those resources available.

The NGO community in the context of HRHCA missions

To fully incorporate NGOs in the missions and leverage their resources, Navy planners must be knowledgeable about the range of those resources and the types of organizations in which they reside. The types of NGOs that participate in sea-based HRHCA missions and the nature of their participation define the barriers that arise when trying to create effective working relationships.

The NGO community is heterogeneous, and there are important distinctions among the institutions that compose the community. We identified five key dimensions along which NGOs can differ and

which may affect NGOs' views on coordinating with the Navy on sea-based HRHCA missions.

First, many NGOs strictly adhere to the humanitarian principles of humanity, impartiality, and neutrality and may not be willing to engage in activities with the U.S. military. Other NGOs may have different interpretations of activities that fall within the bounds of these principles, and not all NGOs strictly adhere to these principles.

Second, there is substantial variation in the types of aid that NGOs provide. We identified two key aid distinctions that are especially important for understanding Navy-NGO coordination for HRHCA missions: humanitarian assistance (HA) vs. other aid, and direct medical services vs. general health services.

Third, NGOs have a variety of different organizational structures. Some NGOs rely heavily on volunteer personnel, while others are primarily staff based. In addition, NGOs vary in their approaches to mission service. Some NGOs (e.g., those with which the Navy has worked on past HRHCA missions) conduct episodic missions in developing countries to provide medical care and training to underserved populations. However, most NGOs focus on ongoing, permanently located missions in specific communities or regions.

Fourth, NGOs vary in terms of several aspects of funding. Some NGOs have reliable levels of funding that allow them to accurately predict future funding levels, whereas other NGOs do not have the same advantages with regard to reliability, level, and timing of funding. Many NGOs also face donor constraints. Some donors earmark their donations for specific projects or activities, which may limit funding availability for NGO participation in HRHCA missions. Finally, NGOs vary in the extent to which they accept and rely on government funding.

Fifth, NGOs differ significantly in their attitudes toward working with the military. The attitudinal differences can be attributed to a variety of factors, but NGOs are increasingly recognizing the need to, at a minimum, coordinate with the military in order to share an operational environment.

This heterogeneity in the NGO community has important implications for Navy-NGO coordination for HRHCA missions. In order to identify NGOs that are likely to coordinate with the Navy, the Navy should look for common ground in three areas:

- Organizational philosophy
- Mission- or project-specific objectives
- Operational approach.

Barriers

The differences among NGOs will define the barriers to participating in HRHCA missions. These barriers can be found at the strategic, operational, and tactical levels.

Strategic-level barriers are philosophical differences on why and how health assistance should be provided to underserved populations. These differences are most likely to keep an NGO from participating in HRHCA missions altogether. In interviews and at conferences, we heard NGO representatives and other civilians identify the following strategic barriers to NGO cooperation in sea-based HRHCA missions.

- There is concern that the military does not understand or appreciate the importance of the humanitarian principles to NGOs' safety and livelihood. NGOs struggle with how their organizations will be perceived globally if they work with the military.
- The terminology that the U.S. military uses to describe HRHCA missions and the role of NGOs can be a barrier to participation. Specifically, many NGOs object to the way the military uses the words *humanitarian*, *partnership*, and *force multiplier* for HRHCA missions.
- Many NGOs believe that HRHCA missions take an inappropriate approach to the provision of medical and civic assistance. Many NGOs wanted to see a long-term plan for sustainability of the project in the community and feared that some short-term care could do more harm than good.

- Some NGOs believe that it is inappropriate for the military to be engaged in humanitarian assistance work both because they are not neutral actors and it is not their area of expertise.
- The military has not yet clearly articulated why it wants NGOs to participate in HRHCA missions. Some NGOs stated that they would be more open to working with the missions if the Navy's reasons for conducting them and for including other institutions were transparent.
- The Navy site selection and needs assessment process left some NGO personnel with the impression that the Navy chooses site visits according to political objectives and provides services according to the Navy's capabilities, instead of serving the populations most in need.

We also identified five operational barriers to NGO participation in Navy HRHCA missions. These are found mostly in the planning stages of an HRHCA mission, but also in the approach to how an operation is conducted.

- NGO personnel were frustrated with the site selection and needs assessment processes because many preidentified surgery patients were denied care as a result of miscommunications. In addition, NGO personnel were frustrated that some of the patients with the greatest needs did not receive care.
- NGOs need to be informed of a final schedule at least 6 months before the mission in order to coordinate with the Navy and organize their resources and personnel. Last-minute changes to schedules create significant problems for NGOs.
- In previous missions, the successes of the military-NGO relationship aboard ship were heavily dependent on the commodore's approach to NGO integration.
- Some NGOs may be inhibited from participating in military-led HRHCA missions because of concerns that their donor base may disapprove.

- The HRHCA mission platform (white-hull hospital ship or gray-hull warships) affected the NGOs' participation in the mission. NGOs had opinions on both the symbolism of the vessel—a minority of NGOs preferred the hospital ship because of its symbolic “neutrality”—and the capabilities needed for transporting and berthing during an HRHCA mission. Most preferred the capabilities of the warship.

Finally, we identified several tactical barriers to NGO coordination in Navy HRHCA missions. Tactical barriers can deter NGOs from participating in Navy HRHCA missions or prompt them to leave the mission early. These tactical barriers include guidance on credentialing NGO medical professionals; the ship-to-shore transportation, specifically with regard to hospital ships; military uniforms worn during HRHCA missions; appropriate followup care and patient medical records; NGO-military liaison aboard ship; procedures for minor surgeries that do not require the ship's operating room; and logistical details, such as visa regulations and procedures.

Recommendations

First, to enable effective long-term strategic planning for Navy Medicine, we recommend that BUMED and M5 be given clear guidance from DOD and the Navy on both the purpose of working with NGOs on HRHCA missions and the priority placed on staffing for HRHCA missions relative to staffing for the benefits and wartime missions.

Second, to improve Navy-NGO coordination on HRHCA missions, we recommend that the Navy move away from thinking about NGO participation as an end in and of itself, and move toward thinking about working with NGOs as a way to enhance the strategic and operational effectiveness of the missions. To support this change in approach, we make five sets of recommendations, which are summarized below.

Use a planning framework

We recommend that the Navy adopt a systematic approach to planning and executing the missions. Specifically, we propose the fol-

lowing four-step planning framework, which focuses on common ground and synergies:

1. Articulate mission objectives
 - Assure friends and allies
 - Train for disaster response
 - Provide care and service to underserved populations
2. Together with NGOs, identify common ground
 - Organizational philosophy
 - Mission objectives
 - Operational approach
3. Decide to coordinate
4. Work out how to coordinate
 - Identify synergistic resources
 - Assign roles
 - Address operational and tactical barriers.

Develop requirements for manpower and personnel

To facilitate the creation of a standard process for integrating embarked NGOs into Navy HRHCA, we recommend first developing formal Navy medical manpower requirements for HRHCA missions. We also strongly recommend that NGO medical professionals **not** be expected to systematically offset Navy medical personnel requirements for HRHCA missions. Decrementing and augmenting, however, have been done successfully on past missions and could be done in the future.

Overcome strategic barriers to create new opportunities for coordination

To develop relationships with a wider range of NGOs, we recommend that the Navy work with the COCOMs and DOD to address the strategic barriers cited by these organizations as reasons for not participating in Navy-led HRHCA missions. We specifically recommend addressing three of the most frequently mentioned strategic barriers:

- The Navy should adopt terminology that is consistent with that being used in the broader community of humanitarian assistance providers.
- The Navy and mission planners should be clear about why they are asking for NGO participation.
- Mission planners need to clearly show that HRHCA missions treat the “most in need” and that provision of free care will not undermine existing health care delivery systems.

Overcome operational barriers to improve coordination

To facilitate coordination with NGOs, Navy planners should continue to incorporate lessons learned from previous missions. We provide four recommendations regarding three key barriers:

- **NGO solicitation:** To work more effectively with host nation NGOs, we recommend that mission planners work as closely as possible with the U.S. Agency for International Development (USAID).
- **Scheduling:** Planners should continue to strive to give NGOs as much notice as possible on the mission schedule and any changes to it.
- **Time commitment:** When inviting medical-focused NGOs to embark personnel, the Navy may consider stipulating a minimum time commitment of 10 to 14 days.
- **Specialty selection:** In the past, the Navy has accepted embarked personnel regardless of specialty. In the future, the Navy should consider being more selective to ensure that NGO expertise matches the services being performed.

Make a change in the approach to coordination that may increase synergies

Finally, we make four recommendations to increase not only Navy-NGO synergies but also the positive impact of sea-based HRHCA missions:

- NGOs should be further integrated into the mission planning process, and NGOs should be consulted on such topics as project selection, site selection, and needs assessment.
- HRHCA planners should seek to work with organizations that have local knowledge and local or regional presence.
- Mission planners should look for opportunities to support ongoing projects being conducted by in-country NGOs.
- The Navy and the military should approach working with NGOs as a learning opportunity.

Introduction

This study was sponsored by the Bureau of Navy Medicine's (BUMED's) Deputy Chief of Staff, Future Plans and Strategy (M5) to inform policies for planning, conducting, and manning the medical element of deliberately planned Humanitarian and Civic Assistance missions executed from the sea.

Background and tasking

Our experience with the 2004 Indian Ocean tsunami relief effort revealed the tremendous influence of DOD-led humanitarian operations in reinforcing a positive view of the U.S. while countering ideological support for terrorism. Since then, we have adjusted our priorities and resources to achieve those effects through *deliberately planned humanitarian assistance* efforts [emphasis added]. The paramount event of this type in 2006 was the deployment of the Navy hospital ship USNS *Mercy*.

*Admiral Timothy J. Keating,
U.S. Navy Commander, U.S. Pacific Command (PACOM)¹*

Under current law, when the U.S. military delivers planned humanitarian assistance to foreign nations, it is called Humanitarian and Civic Assistance (HCA) and is authorized under Section 401 of Title 10 of the United States Code (10USC401). According to 10USC401, the military can carry out HCA activities in conjunction with authorized military operations if they promote the security interests of both the United States and the country in which the activities occur as well as the specific operational readiness skills of the Servicemembers who participate. The code defines authorized HCA activities as:

¹ Statement before the Senate Armed Services Committee on PACOM posture, 24 April 2007.

- Medical, dental, and veterinary care provided in areas of a country that are rural or are underserved by medical, dental, and veterinary professionals, respectively.
- Construction of rudimentary surface transportation systems.
- Well drilling and construction of basic sanitation facilities.
- Rudimentary construction and repair of public facilities.
- Detection and clearance of landmines, including activities relating to the furnishing of education, training, and technical assistance with respect to the detection and clearance of landmines.

Department of Defense (DOD) Directive 2205.2 (6 October 1994) delegates the responsibility for planning and executing HCA to the Combatant Commanders (COCOMs) who incorporate HCA missions into their theater security cooperation plans (TSCP). The perceived success of *Mercy*'s deployment in response to the Southeast Asian tsunami disaster highlighted the potential value of planned health-related humanitarian assistance as a strategic shaping tool. Since then, high-level guidance found in such documents as DOD Directive 3000.05 and the 2007 Maritime Strategy has elevated stability operations, including HCA, to a core military and naval capability.

Before 2005, HCA missions were primarily land-based missions, departing from forward operating locations in a given region to underserved areas in the same region.² Health-related land-based missions—Medical Readiness Training Exercises (MEDRETEs) or Medical/Dental Civil Action Programs (MEDCAPs/DENCAPs)—usually last from 2 days to 2 weeks and typically include a 15- to 30-

² Exceptions include a one-time HCA mission to the Philippines in 1987, the annual West African Training Cruises (WATC) initiated in 1998, and the NATO joint training exercise Medical Central Europe in 2002 (MEDCEUR 02).

person medical element made up³ of reservists and/or deployed personnel from expeditionary units.

Since the 2005 *Mercy* deployment, sea-based missions have been increasingly seen as a high-impact way to deliver health-related HCA (HRHCA). In the 2 years after the disaster, the Navy took the lead in conducting three highly publicized sea-based HRHCA missions. In 2006, to follow up on the goodwill generated by the tsunami response, Commander, U.S. Pacific Command (COMUSPACOM) sent *Mercy* to revisit the still recovering areas it served after the disaster. In 2007, as part of that year's PACOM TSCP, USS *Peleliu* brought medical teams to deliver assistance to other parts of the region. Also in 2007, USNS *Comfort* deployed on an HRHCA mission to the Latin America region, thus adding an HCA element to the U.S. Southern Command's (SOUTHCOM's) "Partnership for the Americas" program.

Lasting from 120 to 160 days, visiting 4 to 12 countries, and providing nearly the full range of HCA activities, these three sea-based missions were longer, larger, and more complex than traditional land-based HCA missions. Within this context, the medical personnel component was also bigger—from 120 to 320 military medical personnel—and the range of medical services provided was much wider, including complex surgeries provided onboard ship. To fill this personnel requirement, it was necessary to draw the bulk of the medical professionals from U.S.-based medical treatment facilities (MTFs) where they were assigned to treat beneficiaries of the Military Health System, as well as wounded Servicemembers.

An additional element of complexity was introduced by the participation of civilians on the sea-based HRHCA missions. The same guidance that elevates HCA to a core mission also calls for increased civilian-military cooperation across the spectrum of civilian agencies, including nongovernmental organizations (NGOs). Such guidance identifies the building of partner nations' capacity to respond to disaster and the establishment of strong civil-military relation-

³ This description of MEDRETEs, MEDCAPs, and DENCAPs came mainly from [1]. It was informally confirmed by reviewing public media announcements describing various land-based missions in multiple regions.

ships before disaster strikes as the primary reasons for working with NGOs. In response to this guidance, inclusion of NGOs was part of the concept of operations for all three of the recent sea-based HRHCA missions.

Although some of the strategic reasons for working with NGOs have been articulated, there is not yet clear guidance on how to work with NGOs in the HRHCA context or how to account for them in the resourcing and planning processes. In its role as a force provider, BUMED supplies the necessary resources to support the COCOMs as they conduct HRHCA missions around the world. In addition, a key function of M5 is to collaborate and liaise between BUMED and Navy, other Services, the U.S Government, civil agencies, and coalition partners to improve communication and prevent duplication of effort. Thus, M5 asked the Center for Naval Analyses (CNA) to investigate how to best work with NGOs to deliver effective sea-based HRHCA. In particular, we were asked to identify key NGO resources and ways to leverage them as well as barriers that prohibit or inhibit NGOs from working with the Navy and ways to eliminate or overcome them.

Study scope and parameters

Activities addressed

This study focuses on Navy-NGO coordination during deliberately planned, sea-based HRHCA missions. Conducted in permissive, noncrisis environments, HRHCA activities occupy a gray area between relief operations and development work.

We do not directly address the special coordination issues associated with humanitarian assistance delivered during disaster response (DR) or during conflict. We do, however, hope that some of the lessons learned from this study can be applied in these more urgent and complex contexts to improve interaction whenever the military and NGOs are operating in the same space.

Finally, although the discussion will show that some members of the humanitarian and development communities consider HRHCA to

be an inappropriate activity for a military service, our tasking requires that we focus on **how**, not **whether**, to do the missions.

Target NGOs

The Navy-NGO coordination issues addressed in this study potentially apply to three groups of NGOs:

- NGOs that provide medical and other personnel who embark on Navy ships to provide medical services, training, and/or supplies
- NGOs that traditionally provide humanitarian assistance during disasters and/or in conflict environments
- NGOs that conduct health-related relief and/or development projects in host countries.

NGOs that have consistently participated on past HRHCA missions (and have indicated that they are likely to participate on future missions) belong primarily to the first group. In the course of executing the missions, the Navy has, however, begun to understand that it must also reach out to other NGOs. Specifically, working with those in the second group can increase the likelihood that HRCHA missions improve coordination during disaster response, and working with NGOs in the third group can help ensure that the missions have no adverse effects on the populations they're intended to serve or on local health institutions.

NGOs are just one group of civilians with which the Navy needs to engage. Other important actors include personnel from other U.S. government agencies, such as the Department of State (DOS) and the U.S. Agency for International Development (USAID), as well as personnel from international organizations, such as the World Health Organization (WHO) and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA). Although we interviewed representatives from some of these other agencies and include their perspectives where relevant, the operational focus is on coordination with NGOs.

Audience and perspective

The primary audience for this report is the study sponsor (M5) and other Navy commands. The secondary audience is the broader DOD community. Potential readers outside DOD, such as those from other government agencies and NGOs, make up a tertiary audience.

Since the report is primarily aimed at Navy planners and decision-makers, it is written mainly from a Navy-centric perspective. The framing of the issues, in particular, reflects the Navy's current views and thinking. NGO perspectives are, however, introduced at various key points, especially when differences in perspectives constitute barriers to the development of effective working relationships.

Language/terminology

Later in the paper, we will describe how differences in language and terminology also constitute barriers to effective Navy-NGO cooperation. In some cases, a barrier is raised because Navy and NGO personnel use the same words to describe different phenomena. In other cases, a barrier is raised because Navy personnel use language that some members of the NGO community interpret as reflecting ignorance about how NGOs operate and/or insensitivity to important philosophical and safety concerns.

Throughout the paper, we try to use neutral terminology and to define terms that carry dual meanings. In this introduction, for example, we have avoided the words *partner*, *integration*, and *collaboration* in favor of the word *coordination* to describe the hoped-for interaction between the Navy and NGOs. For purposes of this discussion, *coordination* is used to capture the notion of mutually beneficial working relationships between equal actors. In other words, it is not intended to imply that NGOs are being coordinated **by** the Navy but rather that the Navy and NGOs are engaged **with** each other in coordinated activities.

Despite these efforts at neutrality, we acknowledge that in some places the language, like the perspective, is distinctly Navy or military. In particular, we have kept the phrase *NGO resources to leverage*

because it was an explicit part of our tasking. As the perspective evolves, however, so does the language.

Approach

Analytical framework

Our investigation was guided by the following logical construct: Navy-NGO coordination should be driven by strategic considerations for both parties. From the Navy's perspective, the objectives of HRHCA missions should inform the reasons for seeking to work with NGOs to carry them out. The reasons for working with NGOs should, in turn, inform the Navy's thinking on how, when, and with what the types of NGOs it can most productively coordinate. The types of organizations and the nature of the coordination, in *their* turn, then define the barriers that arise when trying to create effective working teams from members of organizations with different cultures and potentially competing missions.

In applying this construct, we keep in mind the fact that coordination and cooperation occur at both the organizational and personal levels. If organizational objectives and processes aren't clearly defined and embraced, interaction at the personal level may not work to serve organizational ends.

Three-pronged data collection effort

This research is based not on quantitative analysis but on the collection and synthesis of information and perspectives from three general sources:

- Written and online documents and articles
- Informal interviews and conference participation
- Comments from an external review panel.

Written sources

We began by reviewing federal legislation, formal U.S. government directives and guidance, and assessments of past missions to understand the advent of sea-based HRHCA: What is it, what's new about it, and why and how is the Navy doing it? The answers to these general questions define the context for the investigation of Navy-NGO coordination by describing what type of coordination the Navy has sought and is seeking, and why.

To provide context for the information gathered in interviews and at conferences, we also read articles and other literature on NGO institutional structures and philosophies and military-NGO interaction. NGO websites also provided useful information.

Interviews and conferences

The second method of collecting information was informal interviews with both military and civilian personnel who participate in HCA, DR, and/or development activities. In addition to conducting individual interviews, we also attended several conferences whose participants included representatives from the military, the U.S. government, and NGOs and at which issues of military-NGO cooperation were discussed.

General descriptions follow of the types of military and civilian personnel we contacted for the study. See the appendix for a complete list of the offices and organizations whose representatives were interviewed, as well as the conferences attended.

We interviewed a range of military personnel who reflected different areas of involvement with HRHCA missions. To get a broad view of the reasons for working with NGOs to conduct HRHCA missions, we interviewed people from the Office of the Secretary of Defense (OSD) who have responsibility for making policy decisions about both resources and strategy. To get a more detailed view of how to work with NGOs, we interviewed Navy medical personnel who were responsible for planning and executing the recent HRHCA missions.

In selecting NGOs and other organizations to contact for interviews, we did not attempt to do a comprehensive survey or generate a rep-

representative sample. Rather, we chose a few organizations from the target NGO categories listed earlier to get a feel for the issues and barriers. In addition, we interviewed personnel from organizations that are considered to operate in the humanitarian space doing either DR or development.

Expert review panel

After the literature review and interviews were complete, a first draft of the report was written and submitted for review by four experts in the field of military-civilian interaction. The reviewers added insights based on their own perspectives and also helped answer the question, did our first draft get it right? Unfortunately, the project timeline did not allow for a second review by the panel members to assess how their input was incorporated into this final draft. Thus, any remaining errors are our own. The names of the reviewers are listed in the appendix.

Document outline

We begin by providing context for the analysis by first reviewing the official DOD guidance for conducting HRHCA missions and for working with NGOs. This context is then more fully fleshed out with a review of the three recent sea-based missions, which demonstrate how the guidance has been operationalized.

Next, we lay out the beginnings of a framework for planners to employ when thinking about how to coordinate with NGOs to increase the effectiveness of HRHCA missions. This beginning includes identifying the types of NGO resources to be leveraged and the roles that NGOs might play in order to make such resources available. These first two sections are written largely from a Navy perspective.

The next section introduces the NGO perspective and adds to the framework by describing the NGO community in a way that informs a mutually beneficial way of approaching Navy-NGO coordination. We also describe a range of barriers to coordination that, at worst, keep organizations from engaging at all or, at least, inhibit efficient coordination.

We conclude the memorandum by bringing the previous two sections together in a completed framework for synergistic Navy-NGO coordination. We also make recommendations for how to overcome some of the key barriers to participation.

Recent sea-based HRHCA missions

In 2006 and 2007, the U.S. military conducted several sea-based HRHCA missions, using different platforms and providing services to several nations in the SOUTHCOM and PACOM areas of responsibility (AORs). Both COCOMs have plans for several more deployments in the coming years.⁴

In 2006, USNS *Mercy*, a hospital ship with a white-painted hull bearing a large red cross, deployed to Southeast Asia on a goodwill mission, making port visits in Guam, Papua New Guinea, Indonesia, the Philippines, East Timor, and Bangladesh. Such NGOs as Aloha Medical Mission, Project HOPE, Operation Smile, and CARE International participated in the mission.

After the perceived success of the 2006 *Mercy* mission, SOUTHCOM and PACOM made plans to conduct sea-based HRHCA missions the following year. In 2007, SOUTHCOM deployed USNS *Comfort* (another hospital ship) to 12 Central American, South American, and Caribbean nations (Belize, Guatemala, Panama, Nicaragua, El Salvador, Peru, Ecuador, Colombia, Haiti, Trinidad and Tobago, Guyana, and Surinam). NGOs that participated in the mission in various ways included Project HOPE, Operation Smile, and the Atlanta Rotary Club [2].

Also in 2007, PACOM deployed USS *Peleliu*, a gray-hulled amphibious assault ship with significant medical capabilities, as part of the "Pacific Partnership" program for Southeast Asia and Oceania. USS *Peleliu* visited the Republic of Palau, Guam, the Philippines, Vietnam, Papua New Guinea, the Solomon Islands, the Marshall Islands, and Singapore. Aloha Medical Mission, Project HOPE, and the University of Southern California Pre-Dental Society were among the

⁴ At the time of writing, the U.S. Navy planned to deploy USNS *Mercy* for Pacific Partnership 2008 in PACOM and to deploy USS *Boxer* and USS *Kearsarge* for Continuing Promise 2008 in SOUTHCOM.

NGOs that participated in the mission. Several foreign nations also participated in this mission (primarily through the deployment of civilian and military observers and medical professionals), including Australia, Canada, India, Japan, the Republic of Korea, Malaysia, Papua New Guinea, and Singapore [3].

Formal guidance for HCA missions and military-NGO coordination

A variety of guidance is available for military commanders on both conducting HCA activities (including HRHCA) and coordinating with NGOs. In this section, we review some aspects of that guidance to highlight the strategic objectives of HCA and the importance of working with NGOs to achieve those objectives.

Authorities and guidance for HCA

As noted in the Introduction, congressional authorization for the military to conduct HCA is provided under 10USC401. Consistent with that legislation, DOD Directive 2205.2 then delegates the responsibility for planning and executing HCA to the COCOMs and more broadly establishes DOD's HCA policies. In particular, Directive 2205.2 further defines HCA activities and their objectives. For the purposes of this study, four of these additional elements are especially important because they relate to some of the barriers to Navy-NGO coordination that will be raised later. They are:

- HCA activities must promote the foreign policy interests of the United States.
- HCA activities shall complement, and may not duplicate, any other form of social or economic assistance that may be provided to the country concerned by any other Department or Agency of the United States.
- HCA activities shall serve the basic economic and social needs of the people of the country concerned.
- To ensure that the proper training experience is gained by U.S. Forces participating in HA activities, a reasonable bal-

ance must be maintained between U.S. Forces and whatever foreign troops are participating.⁵

We also note that, in its explicit definition of HCA, Directive 2205.2 does not include mine-clearing activities described in 10USC 401, so its focus is primarily on the activities that we include in our definition of HRHCA.

In addition to this targeted guidance, the *Joint Doctrine for Military Operations Other Than War* (MOOTW) [4] elaborates the strategic reasons for engaging in the wide range of MOOTW activities, which include HCA. In particular, HCA and other activities are expected to support deterrence and promote stability by enhancing a climate of peaceful cooperation. Furthermore, a forward U.S. presence can demonstrate the U.S. commitment to a region and lend credibility to its allies while promoting U.S. influence and access.

Guidance and doctrine for military-NGO coordination for HCA

Based on our review of publicly available documents, [4] is also the main source of guidance for military-NGO coordination during HCA missions. According to [4], a key principle of MOOTW is unity of effort to ensure that all means are directed to a common purpose. Consistent with this concept, [4] highlights the importance of including NGOs in the planning process for any operation: "In MOOTW, joint force commanders should be prepared to coordinate civilian and military actions." The guidance goes on to say that it is important for commanders and mission planners to learn about the roles of NGOs and how they influence mission accomplishment.

In addition to enhancing unity of effort, the guidance identifies working with NGOs as inherently valuable because of the local knowledge and experience they're likely to bring to the table. Specifically, the guidance encourages commanders to coordinate with NGOs to "gain greater understanding of the situation and the society involved."

⁵ Each bullet is a direct quotation from Directive 2205.2, though they don't appear in this exact order.

The Joint Task Force Commander's Handbook for Peace Operations [5] is a second source of guidance for military-NGO coordination. Although peace operations differ from HCA—in that they are likely to occur in nonpermissive environments and the humanitarian aspects may be more urgent—[5] still provides relevant information regarding the strategic value of working with NGOs. In particular, [5] acknowledges the persistent presence of NGOs in developing countries both before and after crises occur, which is where and when HRHCA missions are likely to take place:

Where long-term problems precede a deepening crisis, NGO, PVO [private voluntary organization], and others are frequently on scene before US forces and are willing to operate in high-risk areas. They will most likely remain long after military forces have departed. NGO and PVO are primarily engaged in sustainable development programs; that is, they are working long-term to improve the capacities of HN [host nation] institutions to enhance health, education, economic development, and other conditions in these countries.

Reference [5] also provides some general guidance on **how** the military can work with NGOs. As a starting place, [5] emphasizes the importance of the interagency process in creating unity of effort with all civilian organizations, including NGOs. Specifically, [5] indicates that understanding the interagency process is key to understanding how the skills and resources of each organization can assist in mission accomplishment. This is especially true given the large number of NGOs operating in any given area and the fact that they vary widely in terms of mission focus, size, and attitudes toward working with the military. Many of these NGOs may, however, already have working relationships with other U.S. government agencies.

Finally, [5] also recommends that the military conduct “planning, preparation, and training with NGOs prior to deployment and at other times, as appropriate and within operational constraints.” This recommendation has special relevance for HRHCA since it

must, by law, satisfy training requirements and it may be seen as practice for DR.⁶

Recent guidance that elevates the status of HCA and NGO coordination

All the guidance referenced in the foregoing paragraphs was developed and disseminated in the mid-1990s. The events of September 11th, 2001, however, increased the importance of noncombat operations for the military, resulting in a renewed focus on both HCA and working with NGOs. This is reflected in recent documents and directives related to high-level security policies and strategies.

First, in November 2005, the Pentagon released DOD Directive 3000.05 [6] to articulate its new policies for military support for Stability, Security, Transition, and Reconstruction Operations (SSTRO). This Directive is important because it establishes stability operations, which include HCA, as a core U.S. military mission that “shall be given priority comparable to combat operations.” The Directive further specifies that successful stability operations require that the Department of Defense be prepared to work closely with a wide range of civilian actors, including NGOs.

In 2006, both the National Security Strategy [7] (issued by the Executive Branch) and the Quadrennial Defense Review [8] (published by DOD) reiterate these themes:

In the cause of ending tyranny and promoting effective democracy, we will employ the full array of political, economic, diplomatic, and other tools at our disposal, including...forming creative partnerships with nongovernmental organizations and other civil society voices to support and reinforce their work. [7]

Th[e] operational Total Force must remain prepared for complex operations at home or abroad, including working with other U.S. agencies, allies, partners and nongovernmental organizations. [8]

⁶ Reference [5] also lists several important operational considerations for military commanders working with NGOs.

Finally, in 2007, the Navy, the Marine Corps, and the Coast Guard jointly released a new Maritime Strategy, officially known as *A Cooperative Strategy for 21st Century Seapower* [9]. Consistent with DOD Directive 3000.05, [9] identifies humanitarian assistance and disaster relief (HA/DR) as a core capability and states that “[the sea services] will continue to mitigate human suffering as the vanguard of interagency and multinational efforts, both in a *deliberate, proactive fashion* and in response to crises” [emphasis added]. Despite the fact that the term *HCA* is not used, the strategy clearly implies that HCA—which is done in a deliberate, proactive fashion—is a priority for the sea services.

Operationalizing the guidance: Previous HRHCA missions⁷

This subsection examines the ways in which commanders operationalized the guidance during the 2006 *Mercy*, 2007 *Comfort*, and 2007 *Peleliu* HRHCA missions. These first HRHCA missions were planned quickly and with limited processes for incorporating input from NGOs and partner nations. In all three cases, the primary ship (hospital ship or amphibious assault ship) embarked on a solo journey to visit partner nations and provide medical care. The ships carried with them trained medical professionals, advanced surgical facilities and health care equipment, medicines and vaccines, such health aides as eyeglasses and walking sticks, large-scale water purification systems, public health experts, construction teams, civil affairs teams, and the Navy (or Fleet) band.

The most complete documentation thus far is for the 2006 *Mercy* deployment; studies assessing the other missions are still in progress. In addition, the missions are evolving over time as lessons are learned from one mission and incorporated into the next. As a result, this subsection is a generalization across all the missions, although specific examples are cited whenever possible.

⁷ Unless attributed to a specific source, the information in this subsection comes from our interviews with U.S. Navy personnel and participation at the mid-planning and lessons-learned conferences for the *Comfort* deployment.

Mission objectives and CONOPS

The mission objectives for the 2006 *Mercy*, 2007 *Comfort*, and 2007 *Peleliu* deployments were strikingly similar. All three missions shared the objectives of training military members (and, in some cases, first responders) for HA/DR, enhancing stability and security, and building partner capacity through direct engagement or support of regional partnerships.⁸

Comfort's concept of operations (CONOPS) exemplifies that used by the COCOMs in planning HRHCA missions. *Comfort* planned to deploy for 120 days and planned to provide medical services for a total of 85 days in the Caribbean and Central America. The CONOPS stipulated that *Comfort* would visit 12 countries to provide medical services, and each country visit would last about 8 days total, plus or minus 1 day, depending on medical requirements in each country. The CONOPS also included 10 days for logistics and port visits. The helicopter detachment attached in Norfolk, VA, and the medical teams also embarked/debarked from Norfolk. In addition, the CONOPS stipulated that the Surgeon General would host ship-board regional pandemic influenza conferences in the vicinity of Trinidad/Tobago and Panama [11].

Working with NGOs was also a primary component of all three missions. According to [12], the integration of NGOs was one of *Mercy's* Mission Essential Tasks, and throughout the 2006 deployment *Mercy's* local mission statements included: "Maximize integration with NGOs embarked and ashore and establish a foundation for long term collaborative HADR efforts."

Similarly, the role for NGO participation in HRHCA missions was described in *Comfort's* deployment objectives and planning factors. A key deployment objective was to ensure U.S. military training, specifically training for "U.S. military and civilian medical personnel in a collaborative effort to provide humanitarian assistance" [11]. Although NGOs are not directly referenced, they qualify as civilian medical personnel. Another deployment objective was to encourage regional partnerships through the establishment of new relation-

⁸ See [2, 3, and 10] for online fact files on the *Comfort*, *Peleliu*, and *Mercy* deployments.

ships “between/among nations, NGOs, and international organizations” [11].

NGOs were also a consideration in the planning factors for the *Comfort* deployment. The planning factors note that *Comfort* personnel will “partner with NGOs and regional medical professionals in...ports,” if they are available and coordination is appropriate. However, this reference in particular and the planning documents in general do not address the role of embarked NGOs, despite the fact that many NGO personnel were ship-riders [11].

Finally, for the *Peleliu* deployment, a mission objective was “successfully embedding NGOs in operations from a USN gray hull.”⁹ The public affairs guidance stated that the deployment would be “a model of cooperation and deliberate planning with other nations and NGOs,” but no additional information was available on how NGOs would be embedded or what the “model of cooperation” should look like.

Thus, all three missions, included working with NGOs in their mission objectives, CONOPS, and guidance, yet none of the missions detailed the reasons for NGO inclusion in the mission or practical guidance for how to incorporate them.

Planning

The active-duty staffing process

There are both a process and an extant set of requirements (otherwise known as Required Operational Capabilities, or ROCs) for manning hospital and amphibious assault ships for wartime deployments. There are not yet, however, formal requirements or an agreed-on process for staffing HRHCA missions, so each mission has created its own. For the 2006 *Mercy* deployment, the staffing and capabilities determination process had six steps:

⁹ Peleliu Pacific Partnership, Papua New Guinea CONOPS, 07 - 17 Aug 2007.

1. The COCOM decided to conduct an HRHCA mission using a hospital ship, and fleet medical planners created active-duty staffing packages.
2. Based on the staffing packages, a request for medical forces was initiated.
3. BUMED validated the staffing package based on mission goals and personnel availability.
4. The COCOM and BUMED negotiated a final staffing package.
5. Hospital ship leadership determined capabilities based on the mission and approved staffing.
6. Active-duty staffing was decreased as NGO personnel were committed.

Based on this staffing process, the operational medical capabilities for the mission were as much a reflection of the health services the Navy could provide (i.e., supply) as of the partner nations' health needs (i.e., demand).

The majority of the active-duty medical staff for the 2006 *Mercy* deployment was stationed at Naval Medical Center (NMC) San Diego. Based on concerns about the effect of this deployment on workloads at NMC San Diego,¹⁰ when SOUTHCOM deployed *Comfort*, only a small portion of the active-duty medical staff came from the homeport area of Baltimore, MD, and Washington, DC. SOUTHCOM received guidance that the rest of the staff was to be drawn from other locations around the country, so as to minimize the stresses placed on active-duty medical staff in the Baltimore/Washington area. This guidance for the *Comfort* mission reflects the fact that HRHCA missions must compete with staffing requirements for both overseas combat missions and the peacetime benefits mission. As of 2007, the DOD guidance did not seem to

¹⁰ A concurrent CNA study is assessing the financial and performance impact of deployment assignments on medical treatment facilities. This includes an assessment of large-scale deployments, such as the *Mercy* mission.

have clarified priorities for staffing to support the variety of medical-related missions across the spectrum of warfare.

Solicitation of NGOs to embark

As the military created active-duty staffing packages, it concurrently solicited NGOs for participation. Solicitation of embarked NGOs supported mission-specific requirements and decreases in Navy staffing. The process of soliciting NGO participation in the 2006 *Mercy* mission had four steps:

1. The COCOM decided to conduct an HRHCA mission using a hospital ship.
2. The active-duty staffing package was determined through coordination with BUMED.
3. The COCOM/Naval Component Commander invited NGOs to embark medical personnel.
 - a. Direct invitations were issued to known NGOs.
 - b. Indirect invitations were issued to additional NGOs via the USAID.¹¹
4. Planning staff decremented approved active-duty Navy medical staffing according to amount of NGO commitment.

Because the military staffing and NGO solicitation processes occurred concurrently, and because of the lack of operational guidance on working with NGOs, embarked NGO personnel were used in an ad hoc manner to provide a variety of capabilities and to both decrement and augment Navy medical staffing. In particular, the Navy was flexible about the kinds of NGO personnel who could participate in the mission: the mission planners did not refuse any NGO personnel on the basis of their specialties. As a result, the NGO skill set, like the Navy skill set, was more supply-driven than

¹¹ USAID is the principal U.S. government agency to extend assistance to countries recovering from disaster, trying to escape poverty, and engaging in democratic reforms. USAID receives overall foreign policy guidance from the Secretary of State.

demand-driven or based on the needs assessment (which will be described later) [12].

A complicating factor in the NGO solicitation process was the ambiguous guidance regarding how many NGO workers to embark on the ship. DOD Directive 2205.2 stipulates a “reasonable balance” between U.S. forces and whatever foreign troops are participating on the HCA mission. This requirement introduced two sources of ambiguity. First, it was not clear whether it applied to NGOs and, second, this reasonable balance was not defined in a way that could directly inform the planning process (e.g., a maximum of 20 percent non-U.S.-military participation). As a result, the balance of U.S. forces and NGO or foreign military personnel was determined by the planners for each mission.

Coordination with in-country NGOs

USAID is the primary contact for the U.S. military as it seeks to coordinate with in-country NGOs. Not only can USAID invite in-country NGOs to participate in a Navy-planned mission, it can also share its knowledge of the local NGO programs with the military so that the military mission will be more likely to complement, rather than compete with, ongoing activities. The Navy-USAID interaction does not, however, appear to have been consistent across missions.

According to [12], planners for the *Mercy* 2006 mission worked closely with USAID mission health officers in each country to identify both international and indigenous NGOs to participate as appropriate. In contrast, at the mid-planning conference for the *Comfort* 2007 deployment, U.S. military officials working at U.S. embassies in Latin America indicated that, without specific guidance on how to work with USAID to coordinate NGO participation, the extent and quality of this interagency cooperation was highly dependent on previously established personal relationships.

Needs assessments

In executing the three initial sea-based HRHCA missions, planners developed a process of conducting needs assessments before deployment. After the command formulates the initial plans, partner nations formally invite the ship, and a tentative timeframe is estab-

lished, the commander deploys a predeployment site survey (PDSS) team to each partner nation to develop a firm understanding of the area of operations. The PDSS teams visit the partner nations about 6 months before the mission. Their objectives are to meet with partner nation and U.S. Embassy officials to discuss the mission, objectives, resources, needs, logistics, and other planning details. Based on this information, the military planners develop tactical plans for HRHCA missions.

The PDSS team has a general list of capabilities that the military can provide (e.g., cataract surgery) and it seeks input on the site's medical needs from the local officials. Local officials often request additional medical capabilities to treat specific illnesses or conditions that are common in that country or area where the ship will visit (e.g., malaria). The PDSS team may also meet with NGOs or international organizations (IOs) located in the country to learn more about the services they provide and identify the opportunities for synergy. The team then reports the needs assessment to the mission commander and planners.

One month before the mission, the military deploys an advance team (ADVON) to the partner nations. Unlike the PDSS teams that generally stayed in country for a week or two, ADVONs remain in the partner nation until the ship visits. Their purpose is to follow up with partner nation and U.S. Embassy officials and conduct any remaining coordination for the mission.

A few days before the ship pulls into port, a final team is deployed from the ship to the partner nation. That team is responsible for handling any last-minute coordination or preparation for the mission, such as changes in schedules, passport requirements, or other critical details.

Coordination with partner nation (MOH v. MOD)

The needs assessment is most frequently conducted through collaboration with the partner nation's Ministry of Health (MOH) or its equivalent. MOH coordination tends to provide the most comprehensive perspective of the medical needs of the community, and it allows the proper channels of the government to be included in the planning process for HRHCA missions. In some cases, however,

coordination has been conducted through the Ministry of Defense (MOD) because existing military-to-military relationships provided immediate access and ease. In instances when coordination has gone exclusively through the MOD, MOH officials were unhappy because they were excluded from the process. In addition, without MOH support, it is more difficult for the Navy to conduct its medical outreach and training programs, which require support from national, community, and NGO groups.

Coordination with other U.S. government agencies

HRHCA missions are among the most diplomatic of military missions, and they require coordination with the U.S. Department of State (DOS) and other U.S. government agencies. Coordination with DOS occurs mainly at the executive level. The chain of command dictates that the COCOM should consult with the Secretary of Defense, who would then consult with the Secretary of State. The Secretary of State must approve all U.S. government HCA missions conducted overseas.

Mission planners also coordinate with USAID not only to identify in-country NGOs but also to plan other aspects of the missions. For recent deployments, mission planners contacted USAID representatives as soon as partner nations invited the ship to visit. USAID representatives helped the military planners to identify the populations' needs, conduct in-country preparations, prescreen patients, locate sites for ashore medical facilities, advise on cultural issues, advertise the mission, and distribute/manage donated materials after the visit.

As already noted, however, military-USAID coordination has not been consistent across missions or countries. This was confirmed by USAID personnel in interviews and at conferences. In particular, it was suggested that the COCOMs should work with both the DOS and USAID to be sure that the HCA/HRHCA portions of the TSCPs are consistent with overall country programs.

Execution of mission

In executing sea-based HRHCA missions, the ship and its staff provided a variety of medical services during the ship's time in port and at the mission sites ashore.

Services provided

Once the HRHCA missions commenced, the Navy usually provided the same core set of services to partner nations. Navy services to most countries during HRHCA missions included the following:¹²

- Medical personnel exchanges
- Medical and dental outreach (e.g., MEDCAP/DENCAP)
- Onboard surgeries
- Engineering and biomedical equipment repair
- Community relations
- Preventive medicine and public health assessments
- Veterinary care
- Public affairs [13].

Within this core set of services, the precise services provided to each country varied with the country's need, the acceptability of services within the partner nation's political climate, and the logistical ability of the Navy to bring the services to the local area of need. A variety of medical and dental services was provided on all of the HRHCA missions. Direct medical care included, but was not limited to, the following:

- Dental care, such as tooth extractions, fillings, sealants, and fluoride applications
- Pediatric checkups and basic medical evaluations

¹² For more information about these services, see [13].

- Immunizations (e.g., measles, mumps, rubella; tetanus/diphtheria; influenza)
- Deworming
- Ophthalmology surgery (e.g., cataracts)
- Optometry checks and eyewear distribution
- General surgery
- Obstetrical and gynecological consultative care
- Pharmaceutical distribution.

Public health teams also provided a variety of services, which included:

- Food and water system assessments
- Structural assessments
- Vector assessments
- Assistance in establishing public health systems
- Epidemiologic/public health consultation [11].¹³

Training of local personnel

HRHCA missions also provided educational services for local medical providers and the community. The training was provided in two ways. First, detachments of clinical personnel visited clinics ashore to provide care to local populations and to share knowledge with local medical professionals. In this environment, knowledge was shared informally as the clinical professionals worked alongside the local medical professionals. Second, medical teams visited local hospitals and taught classes to partner nation medical professionals. The topics of these classes included nutrition, basic life support, and obstetrics. Whenever possible, the medical teams left behind teaching materials (e.g., practice dolls for CPR, informational brochures) so that their students could continue to learn and teach

¹³ This information was compiled from a variety of news articles covering each of the deployments [11, 14].

others [13]. In some instances, there were opportunities for medical education exchanges, in which U.S. medical teams received training on the local health issues, such as tropical medicine.

Time in country

The length of time spent in each country or port during these sea-based HRHCA missions varied from 5 to 14 days, with the first day devoted to public relations events and prescreening of patients, and the last 2 days reserved for postoperative care and additional public relations events. Thus, the total number of “operating room” days was the total number of days minus 3 days [13].

Even during the shortest visits, the medical personnel were able to perform surgeries, provide public health assessments, conduct a MEDCAP, offer limited medical training, repair equipment, and work on a construction project. In some instances, the shortest port visits were insufficient to provide adequate follow-on care, and some patients remained on board until the next port visit, when they were transported back to their original location [13]. To address this concern, the 2008 HRHCA deployments plan to extend the time in each port to 2 weeks.

Followup care

Many invasive surgical procedures require postoperative care immediately after surgery and during the following weeks. As a result, patients stayed aboard the ship for as long as possible and practical.

After the departure of the ship, patients relied on the local doctors and health care system to provide followup care to evaluate and monitor the healing process, to write/fill prescriptions, and to treat newly diagnosed conditions. In most cases, local care appeared to be sufficient to meet the needs of the patients, but some instances of infection and complications arising from surgical procedures on the ship were beyond the capability or capacity of the local medical facilities to handle. Fortunately, when postoperative complications did occur, the ship was usually close enough to deploy medical

teams to provide additional care.¹⁴ Surgical teams were careful to consider postoperative care when scheduling procedures.

Mission evaluation and assessment

At the time of this writing, all published mission assessments relate to the 2006 *Mercy* deployment since it was the first sea-based HRHCA mission and there has been sufficient time to evaluate its successes and failures. (CNA is concurrently conducting assessments of the 2007 HRHCA missions.) Assessments of the 2006 *Mercy* mission try to evaluate the extent to which it met both its strategic and operational objectives, as well as the success of Navy-NGO coordination. All of these early assessments are based on ad hoc attempts to evaluate the missions and reflect the fact that standard, accepted measures of effectiveness have not been established but are being developed along with operational doctrine. In particular, there is not yet any framework that relates the achievement of operational objectives to the achievement of strategic objectives.

Achievement of strategic objectives

The success of the strategic objectives of “winning the hearts and minds” of the local populations—and countering ideological support for terrorism—has been evaluated through media analysis and public opinion polls in countries where HRHCA missions took place [15].

After *Mercy*’s 2006 deployment to Southeast Asia, Terror Free Tomorrow (TFT)¹⁵ conducted extensive public opinion surveys in Indonesia and Bangladesh. These surveys found that, in Indonesia,

¹⁴ Complications arose from ocular surgery in Indonesia during *Mercy*’s visit in 2006. Fortunately, the ship had sailed to another Indonesian port and was able to redeploy personnel to address the complications.

¹⁵ TFT is a nonprofit polling organization dedicated to determining “why people support or oppose extremism.” TFT surveys have been used by the Congress, Department of State, and DOD, and have been relied on by major media outlets, such as *USA Today*, CBS News, CNN, *Wall Street Journal*, *International Herald Tribune*, *New York Times*, *Washington Post*, and others. For more information, see www.terrorfreetomorrow.org.

85 percent of the people who had heard of *Mercy's* visit had a favorable opinion of it; in Bangladesh, 95 percent of the people who had heard of the visit had a favorable opinion [16]. CNA analysis of the surveys and media coverage of the mission noted that "despite a shorter stay, fewer minutes of news, fewer reporters, and the need for the ship to stay 50 nautical miles off shore, Bangladesh had higher poll numbers for knowledge and favorable ratings than Indonesia" [17]. The reasons for this disparity are unclear, but it demonstrates that the HRHCA mission could create a positive impression even without optimal conditions.

In its surveys, TFT polled a wide range of demographic and political groups, including those that support Osama Bin Laden and approve of suicide attacks, and found that every surveyed group had a favorable impression of *Mercy's* mission. The study concluded that HCA can promote favorable public opinion for the United States, even among populations that are least likely to look favorably on the United States, such as those that support Bin Laden [16].

Achievement of operational objectives

The success of the operational objectives has been measured primarily in terms of medical care provided during the HRHCA missions. Although training is also an operational objective, formal assessments or evaluations of the success of HRHCA as a training mission have not been published [18].

Assessments of medical care provided during HRHCA missions have varied in terms of what is measured and how it is counted. For example, some missions counted the number of patient visits, while other assessments counted the number of treatments provided. For the 2006 *Mercy* deployment, CNA assessed medical care provided based on number of surgeries. On average, for every operating room day in port,¹⁶ the staff of *Mercy* conducted 13 surgeries.¹⁷ In

¹⁶ These data were consistent for 7 port visits.

¹⁷ There were some inconsistencies in the number of surgeries performed in each port due to multiple port visits in certain countries, which enabled doctors to perform more surgeries and keep patients onboard until the next port visit.

addition, *Mercy*'s medical personnel treated an average of about 900 outpatients during 5 port visits [13]. And, although formal assessments of the *Comfort* and *Peleliu* missions are not yet available, the military has reported aggregate figures on services provided during those missions. SOUTHCOM estimates that *Comfort*'s medical teams treated more than 98,000 patients, provided 360,000 treatments, and performed 1,170 surgeries [2]. Similarly, PACFLT estimates that the medical efforts of the *Peleliu* deployment affected about 25,000 people, including the patients and their extended families [14].

Assessment of NGO participation

For all three of the recent sea-based HRHCA missions, NGO participation was part of the mission objectives and a theme in public affairs plans, reflecting the fact that the military believes that coordination with NGOs will improve its impact on the local populations and institutions in the host country. As with the other areas of assessment, however, the Navy has not yet developed or approved metrics by which to assess NGO participation. As a first attempt, CNA assessments of NGO participation in the *Mercy* 2006 deployment examined the number of NGO personnel who participated and the impact they had on the amount of medical care provided.

Mercy embarked seven NGOs and incorporated the workers into various medical and administrative groups.¹⁸ NGOs participated in the mission for various lengths of time; most embarked personnel for three or fewer port visits. While the organizational participation stayed relatively constant, NGO workers rotated frequently, creating a relatively high turnover. This turnover was particularly challenging to manage because workers provided a variety of skills and expertise across the spectrum of medical professions, but their replacement workers did not necessarily have the same expertise. For example, a pediatrician could be replaced by an OR nurse, despite the fact that

¹⁸ Embarked NGOs included the International Relief Team, Operation Smile, Save the Children, CARE International, UCSD Pre-Dental Society, Project HOPE, and Aloha Medical Mission. Personnel from two international organizations—the International Organization for Migration and the Philippine Red Cross—also embarked.

their skills are not interchangeable. Of the participating NGOs, only the UCSD Pre-Dental Society consistently provided volunteers with similar skill sets [12].

Throughout the 2006 *Mercy* deployment, the total number of NGO personnel per port visit fluctuated between 19 and 62.¹⁹ Analysis suggests that the fluctuation in NGO workers did not affect the number of patients served per port visit. In fact, increased participation correlated with neither the busiest ports nor increased capacity for medical treatment facilities. This may be explained by the challenges of accurately predicting workloads in each port (and planning accordingly) and the potential for changes due to unforeseen political challenges or low patient turnout [12]. For whatever reason, on this HRHCA mission, the number of NGO workers present did not increase the number of patients served.²⁰

Finally, the study also found that overstaffing HRHCA missions with NGO personnel reduced individual workloads, which resulted in “unsatisfactory experiences” for both the NGO workers and the U.S. military personnel involved in the mission [12].

Barriers to working with NGOs

To supplement this formal assessment of NGO participation on the *Mercy* deployment, we interviewed personnel who participated in all three missions to develop a more general picture of any difficulties associated with incorporating NGO ship-riders. These interviews revealed that, from the Navy’s perspective, two key operational barriers impede incorporation of embarked NGO personnel in sea-based HRHCA missions: scheduling and time commitment.

Scheduling is difficult because NGOs and the military have different planning cycles, processes, and requirements for lead time. At the organization level, some NGOs need more time than the military to

¹⁹ These counts include personnel from the two international organizations as well as those from the NGOs.

²⁰ If a goal of NGO-Navy coordination is to increase the amount of care provided, then, by that standard, this particular effort would have failed.

prepare and organize for a nonemergency HRHCA mission.²¹ The military contacts NGOs after working out key planning factors, such as the partner nations to visit, the timeframe for the visit, and the type of ship involved. Only after the military has resolved these issues (which can take several months) does it invite NGOs to participate in the mission. As a result, NGOs have a limited, and sometimes insufficient, amount of lead time to recruit volunteers, organize transportation and scheduling, and allocate funding.

To complicate the process, the military cannot always provide firm dates and specific site visits for the mission. The military provides a timeframe for each planned port visit, usually with a window of several days on each end. On the basis of this timeframe and site location, individual NGO ship-riders (who have primarily been unpaid volunteers) must request leave from their professional responsibilities, cover their private responsibilities (e.g., child care, elder care, pet care, house sitting), and make travel arrangements. At this point, the personnel are committed to the dates and locations provided and frequently cannot alter their availability, even if the schedule of the mission shifts. Such planning issues are barriers to individual personnel and their NGOs, which try to replace personnel who are unable to shift with the military's schedule. It is also a barrier to the military planners who cannot receive a guarantee of the NGO personnel and expertise available for the entire mission.

Time commitment may also be a barrier to cooperation because the military would like NGO workers to be engaged with the mission for longer periods of time. Experiences on prior missions have shown that NGO-military operational integration is best when the parties have had a chance to work together for several days. Several of the Navy personnel we interviewed indicated that NGO personnel need to be on board the ship for 10 days to 2 weeks to be most effective and truly integrate with their military counterparts. Previously, people have participated for a week at a time, but after traveling to and from the ship and getting oriented, NGO personnel were only on board and participating in the mission for a few days. In these scenarios, NGO workers were not able to contribute as much as they

²¹ Many NGOs are able to respond rapidly, if not immediately, to emergency situations.

would have liked, and the opportunities for NGO-military operational integration were limited.

Summary

The high-level guidance reviewed in this section defines HCA and identifies its strategic objectives. It also articulates the value of working with NGOs to achieve those objectives. In particular, the guidance acknowledges the importance of unity of effort among all actors in an area of operation, including NGOs, as well as of the local knowledge and special expertise that NGOs bring to the table.

There is also limited doctrine on **how** to work with NGOs. This doctrine does not, however, provide a systematic framework or process for working with NGOs in military HRHCA missions. As a result, COCOMs are left to determine when it is appropriate to include NGOs, how to identify the appropriate NGOs with which to work, and how to include them in the practical aspects of the mission. It is also noteworthy that none of the guidance mentions using NGO personnel as substitutes for military personnel or as providers of additional material resources.

Our review of the assessments of the 2006 *Mercy* mission and our interviews with Navy staff who planned and participated in all three of the recent missions indicate that the high-level guidance hasn't yet been translated into an accepted set of procedures either for conducting sea-based HRHCA in general or for working with NGOs on HRHCA missions. This lack of procedure is reflected in the ad hoc approach to planning, executing, and assessing each of the three missions. For the purposes of this study, four procedural gaps stand out.

First, there is no formal manning requirement for sea-based HRHCA missions. This is largely due to the newness of the missions but also reflects the fact that there is not yet a clear understanding of how the manner in which a mission is executed affects the extent to which it achieves its strategic objectives.

Second, there is no approved process for manning the missions. In 2006, *Mercy* was primarily manned by medical personnel from NMC

San Diego who would have been assigned to the ship in the case of a wartime deployment. In contrast, in 2007, *Comfort* was manned with personnel pulled from a variety of locations across the country in an effort to spread the burden across medical installations. The change in procedure was partially due to learning from the first mission, but we inferred that it was also due to unresolved tension at higher levels about the priority of the HRHCA mission relative to Navy Medicine's other responsibilities.

Third, there are not yet established metrics for assessing the success of HRHCA missions. CNA and Terror Free Tomorrow are using public opinion polls and after-mission interviews to assess the extent to which some of the strategic objectives are being achieved [16, 17]. At the same time, mission planners and participants are using various methods to track the amount and quality of care provided and to capture operational and tactical lessons learned. There is, however, no process for linking operational success or failure to strategic success or failure.

Fourth, successful coordination with NGOs was an objective in all three missions, but the approaches to incorporating personnel were ad hoc and not directly tied to either capability requirements for the missions or their strategic objectives. This can be seen in how NGO ship-riders were solicited for the missions and how their participation is being assessed: no NGO personnel were turned away, regardless of their medical specialties, and incorporation of NGO workers is being assessed primarily using operational and tactical measures.

The first three procedural gaps fall outside the specific scope of this study, but they are important for it because they affect how the Navy has approached working with NGOs: the ad hoc approach to incorporating NGOs follows largely from the ad hoc approach to the missions in general. In particular, the lack of manning procedure has put the emphasis on getting access to NGO medical personnel to replace Navy medical personnel, rather than access to their institutional expertise and experience. At the same time, making NGO integration an objective in and of itself has emphasized operational processes for including NGOs as ship-riders rather than ways to create synergies with a broader range of NGOs to achieve both operational objectives and strategic goals.

How Navy-NGO coordination can improve the effectiveness of sea-based HRHCA missions²²

In accordance with higher headquarters guidance, coordinating with NGOs has been an explicit objective of the recent sea-based HRHCA missions. Our review of the guidance and past practice, however, revealed a gap between the strategic policy guidance for coordination and the development of coordination procedures that allow the missions to fully benefit from the resources NGOs bring to the table. To begin to bridge that gap, this section of the report identifies key NGO resources and discusses how they can be leveraged to improve the effectiveness of HRHCA missions in terms of two basic objectives: service delivery and training.

Before we begin, note that this section is written from the Navy's perspective. Specifically, we have framed the discussion in terms of NGO resources that the Navy might leverage. At one level, this framing reflects our tasking and the project sponsorship. At another level, it incorporates the implicit assumption that "leveraging" works two ways: NGOs that don't see their own leveraging opportunities in coordinating with the Navy on HRHCA missions will not choose to be involved.²³ Thus, the overall vision is that, by combining resources, the Navy and NGOs can create synergies that will lead to better outcomes overall.

²² The discussion in this section represents our synthesis of the high-level guidance that was cited in the previous section and information from our interviews with personnel from the 2006 *Mercy* and the 2007 *Comfort* and *Peleliu* deployments. To a lesser extent, we also drew from our interviews with representatives from NGOs and other civilian organizations.

²³ We explore this more in the next section, which discusses reasons NGOs may choose to cooperate in HRHCA missions.

Objectives of sea-based HRHCA missions that can be better achieved with NGO resources

Provide care and services

The primary operational objective of sea-based HRHCA missions is to provide medical/dental care and public health services to underserved populations in partner nations. Although the U.S. military's highly trained medical and health professionals—combined with the advanced medical facilities aboard ship—ensure that the care and services provided are high quality, the missions have been criticized for their short-term focus, which is seen to negatively affect the quality of the patient-physician relationship.²⁴ According to [19], these criticisms charge that HCA missions can be marred by:

- Lack of knowledge of endemic diseases
- Lack of knowledge of, or consideration for, local customs and beliefs
- Inadequate referral, continuity of care, and followup
- Inadequate planning and coordination
- Disruption of local health care systems
- Raised expectations that cause dissatisfaction with local medical resources.

Given their long-term presence in the countries where they operate, NGOs can help Navy operators plan and execute their missions to avoid these pitfalls.

Train military members

By statutory requirement, HRHCA missions are training missions for the U.S. Servicemembers who participate. The crew on the ship

²⁴ Because of their short duration and mobile platforms, HRHCA missions are often characterized as providing “drive-by” or “tailgate” medicine.

receives training to operate and maintain it. The military medical personnel have an opportunity to practice medicine in foreign locations and austere environments. And, finally, the mission commander and the mission planners learn how to cooperate with a variety of new players, such as partner nation military and civilian medical professionals.

Navy-NGO coordination during HRHCA missions can enhance this training experience because it provides a natural opportunity to jointly train for disaster relief and other emergency scenarios that require the military and NGOs to work together to alleviate human suffering. Specifically, NGO personnel and military medical professionals have the opportunity to work side by side and learn about each other's community and operating procedures. In addition, NGOs add another element to the planning process.

NGO resources that the Navy can leverage

To achieve these objectives, the Navy can leverage, or create synergies with, a variety of NGO resources. This subsection describes three broad resource categories—manpower and supplies, expertise, and experience—and how they can enhance mission outcomes.

Manpower and supplies

Manpower and supplies, the most tangible resources, are the first resources that the Navy can leverage for HRHCA missions. Many NGOs have access to volunteers and/or staff who are willing to deploy with a ship or travel to foreign countries to provide medical care to underserved populations. NGOs can also contribute relevant medical supplies, such as vaccinations, that are donated or purchased with organizational funds. In this discussion, we focus on ways the Navy can leverage NGO personnel resources. We highlight the personnel factor because manning of the missions is a key concern for BUMED, and how to best work with NGOs on HRHCA missions is a fundamental issue being addressed in the study.²⁵

²⁵ This is primarily, but not exclusively, a ship-rider issue.

Our review of the literature and our interviews with Navy personnel revealed three potential models for incorporating NGO personnel in Navy missions:

- To augment military personnel, so that more or different services could be provided with the same number of military personnel
- To decrement military personnel, so that the same services could be provided with fewer military personnel *on a given mission*
- To offset military personnel, so that the same services could be provided and the total military personnel requirement is *systematically* reduced.

Here we discuss the differences between the three approaches to leveraging NGO personnel and the implications for each.

Augment

The Navy may use NGO personnel to augment military personnel; *NGO personnel could be used in addition to a fully staffed military medical component*. This option is predicated on the ability of the military to provide the personnel to meet its manning requirements for the HRHCA mission. Once manning requirements are met, NGO personnel could provide additional capabilities, thus augmenting the capabilities already provided by the military.

In this approach, military personnel fill essential billets, and NGO personnel provide additive value. The services and expertise of NGO workers enhance the capacity of the military mission, yet their participation is not critical to mission execution. This allows the NGOs the flexibility to provide a variety of skill sets, as they are available, including those skills that may be useful, but not essential, to the mission. In this model, the failure of an NGO worker to deploy or stay afloat for the originally agreed-on length of time would not jeopardize the effectiveness and success of the mission.

This approach capitalizes on the unique advantages of both the military and NGOs. Augmenting would require that the military have the resources available to fulfill the manning requirements for

the mission, but it also ensures that all mission-critical billets are filled. This model allows NGO personnel to broaden the aperture of the medical mission and retain flexibly in their commitment.

Decrement

The second approach for leveraging NGO personnel resources is to use NGO personnel to decrement military medical personnel on a mission-specific basis. This approach would begin with the assumption that the military would fill all of the medical manpower requirements for the HRHCA missions. Then, as NGO personnel become available, *they would be "assigned" to billets on an ad hoc basis, thereby replacing the military medical professionals on that particular mission.* Using this model allows more military medical professionals to continue operating in their current assignments (e.g., in theater or at Naval Medical Centers) and potentially provide NGOs with more opportunities to provide medical services during HRHCA missions.

This approach may reduce costs for the military by eliminating the expenses associated with deploying a doctor away from his/her primary location. For every doctor that the military takes from a military health facility, the military has to pay a reservist to substitute for the doctor at his/her primary location, or the other doctors at the facility must absorb the deploying doctor's patient load. In the event that all patients cannot be seen under this arrangement, the military then pays to send patients to private practices. Thus, the deploying and backfilling for medical military personnel is an expensive endeavor that could be mitigated by decrementing manning requirements with NGO personnel and, thus, deploying fewer military medical personnel.

As described in the subsection on NGO solicitation, NGO personnel were used both to augment and to decrement military personnel on the 2006 *Mercy* mission. The assessment of the mission and our discussions with Navy and NGO personnel indicate that both approaches to incorporating NGO personnel have been generally

successful, though issues with managing the NGO personnel still remain [12].²⁶

Offset

It has been suggested that NGO personnel could be used to systematically offset military medical manpower requirements to reduce costs for the military and increase the availability of military medical personnel for deployment elsewhere. In this model, assumptions about *NGO participation would be formally included in the requirements determination and manning processes and would apply to all HRHCA missions*. (In contrast, decrementing would occur on an ad hoc basis depending on the availability of NGO workers for each mission.)

To do this, the Navy would need to have established medical manpower requirements for HRHCA missions.²⁷ These manpower requirements would then be compared with the existing Navy inventory to identify shortfalls—either specialties for which the Navy has positive inventory, but not as much as would be needed to fill a new HRHCA requirement, or specialties for which the Navy has neither current nor planned future inventory. These gaps could then be filled with new/additional Navy personnel or with NGO personnel.

For example, if the HRHCA requirement suggests a need to increase endstrength by 50 medical personnel, a choice might be made to increase endstrength by only 25 personnel and plan for NGO personnel to fill the remaining billets. The billets to be filled by NGO personnel may be for specialties for which there is no current Navy requirement (or expertise), thus eliminating the need to add new specialties to the Navy medical capabilities.

²⁶ The best example of augmenting was the team of Operation Smile volunteers who embarked for about 1 week and, with limited participation from other embarked personnel, performed reconstructive surgeries on 54 patients with cleft lips and cleft palates [12]. (Operation Smile also embarked a surgical team for the *Comfort* deployment.)

²⁷ As described in the previous section, HRHCA missions are relatively new, and the Navy has not yet determined the exact number or type of medical specialists it needs to complete these missions.

Despite its advantages to the military, the offset approach implies a fundamentally different form of Navy-NGO coordination than has been practiced on past missions. Under the offset model, NGOs would be obligated to find personnel to provide specific expertise and services throughout the duration of the deployment. Thus, the offset model effectively requires that NGO personnel be contracted to formally fill manning requirements for HRHCA missions. Although some NGOs may be able to accommodate this type of relationship, it is unlikely to be successful with NGOs that rely primarily on volunteers because of their need for scheduling flexibility, which will be discussed in a later section.

Expertise

As currently staffed, the Navy may not have the expertise necessary to address every facet of an HRHCA mission. NGOs have expertise in two key areas for HRHCA missions: specialized medical care and disaster response. Expertise in each area contributes to both mission objectives.

Medical expertise

NGO personnel have a variety of medical expertise, some of which may not be resident in the military medical system. For example, pediatric endocrinology is a specialty not available within the military medical system, but it may be available through NGOs. In addition, NGOs may have more tropical medicine specialists available than the military, and these practitioners may have more experience working on the types of illnesses and diseases that are common in places where the Navy conducts HRHCA missions. Throughout our investigation, medical expertise is the NGO resource that has received the most attention. The main focus has been how to successfully incorporate NGO medical personnel into the HRHCA missions to either decrement or augment the military medical component.

Preparation for disaster response

Preparation for disaster response is both an objective of HRHCA missions and a reason for the military to work with NGOs. In the

event of a disaster, such as the tsunami in Southeast Asia in 2004 or the earthquake in Pakistan in 2006, it is likely that both the military and NGOs (as well as international organizations, such as the World Health Organization) will provide emergency care for the affected population.

According to the CONOPS for the three recent missions, one objective of sea-based HRHCA missions is to train U.S. military forces for disaster response scenarios. From the military perspective, disaster response missions would be more successful and the military would be better integrated into international disaster response efforts if the military had experience working with the partner nation and other organizations before the crisis. Therefore, training to improve interoperability between the military and NGOs in a disaster response scenario is a key reason for the military to work with NGOs during HRHCA missions. It would potentially be more beneficial to the disaster victims if NGOs and the military were familiar with each other, had institutional or personal experiences working together, knew how to avoid or overcome barriers, and were able to work together effectively to provide the best services and care possible. As one person explained, “the time to exchange business cards is before the disaster.”²⁸

Experience

Experience is another NGO resource that the Navy can leverage for HRHCA missions. Specifically, NGOs have valuable local knowledge and professional networks that can help the military improve its operational access to remote areas and high-need populations. In addition, NGOs have extensive experience in capacity-building activities in the health care sector that can help increase the long-term impact of HRHCA missions.

Operational access and access to local professional networks

The Navy may want to leverage NGO experience because NGOs have longer histories working on humanitarian assistance and

²⁸ *Comfort Lessons Learned Conference*, November 2007.

development issues. Many NGOs already know the major players, problems, and places for humanitarian assistance work, and the Navy could increase the effectiveness of HRHCA missions by leveraging NGO experience and professional networks.

For example, the Navy may want to leverage NGO experience to gain operational access in support of the mission. NGOs traditionally have long-term relationships with populations in poor, underserved areas of the world. The Navy can leverage these networks by working with NGOs that may either provide direct contact to the more remote populations (which otherwise may not know of or welcome U.S. Navy activities) or provide indirect support for the military (NGOs advertising their own coordination with the military may affect the local population's view of the military—i.e., “I trust that NGO and that NGO trusts the military”).

The military may also want to leverage NGO networks to learn more about the medical needs of certain communities. NGO professional networks often include other NGOs, international organizations, partner nation government officials (including those at the regional or village level), and local medical and social organizations. These resources can be powerful assets for motivating people to request medical services, selecting patients for care, tailoring health care for a specific area, and ensuring proper followup medical care.

Partner capacity building

Many NGOs also have experience in partner capacity building as a result of their long-term involvement in development and humanitarian assistance programs. These NGOs have the experience necessary to provide medical and civic assistance in a way that does not undermine existing institutions and is potentially more sustainable in the local environment. Leveraging NGO capacity-building experience could be an effective way to incorporate the NGOs' unique skills and capabilities in HRHCA missions. Building partner capacity for medical care includes a variety of activities, such as:

- Identifying the areas of expertise and locations where the partner nation most needs increased medical capacity
- Developing courses to “train the trainers”

- Preparing “leave behind materials” (e.g., pamphlets and dummy dolls) for the partner nation’s continued training after the HRHCA mission
- Engaging with local institutions that can assume ownership of the medical information and carry it forward
- Interacting with local medical professionals and the local community to develop lasting relationships
- Gaining the perspectives of local medical professionals on the greatest needs to be addressed and the most sustainable way of addressing them
- Supporting existing medical institutions.²⁹

NGOs can assist the military in conducting the aforementioned activities, and they can help to tailor the capacity-building efforts for the partner nation. In addition, NGOs may have the experience to understand the landscape of the existing medical institutions and develop a way for the military to support the existing institutions, so as not to duplicate efforts or undermine ongoing activities. USAID, embassy country teams, and OCHA may also be able to assist the Navy in understanding the environment within a country and in finding ways to support extant programs and institutions.

Roles for NGOs during HRHCA missions

By examining past HRHCA missions, we identified four potential, distinct roles for NGOs on HRHCA missions. These roles describe the location and type of activities in which the NGOs may participate during the mission. These roles are not necessarily mutually exclusive; NGOs may participate in a variety of roles throughout the duration of the mission. From the Navy’s perspective, the role of each NGO would depend on the reasons why the Navy wants to work with that NGO and the resources the Navy seeks to leverage. From the NGOs’ perspective, their role would depend on their mandate and organizational willingness to work with the military in

²⁹ This list was developed through discussions with participants in the 2006 *Mercy*, 2007 *Comfort*, and 2007 *Peleliu* HRHCA missions.

this context, as well as the synergies that can be created with their extant programs.³⁰

Role 1: Help with mission planning

The first suggested role for NGOs in HRHCA missions is to provide help with all phases of mission planning, including project and site selection, needs assessment, and patient selection and screening. Many NGOs have the in-country resources to assist with these advance activities. Planning activities are also compatible with a wide variety of NGO missions.

The NGO resource that is most valuable in this role is experience. Local knowledge of medical needs, social customs, and health institutions would be critical to ensuring that the most important needs are met for the neediest populations. In addition, early involvement with project and site selection may create opportunities for Navy missions to support ongoing NGO programs, thus increasing their long-run impact. Finally, coordinating with NGOs to help HRHCA plan missions can also be good practice for disaster relief.

Role 2: Embark on ship and provide care afloat and ashore

The second role for NGOs during these missions is to embark on the ship and provide medical care afloat and ashore. In this role, NGO personnel would integrate with the military staff, live aboard the ship, and provide the same types of services as the military medical personnel.

The NGO resources that are most relevant for this role are personnel and expertise: NGO ship-riders can fill capability gaps, offset or decrement military personnel, or augment the military capabilities. NGO ship-riders can also practice interoperability by embarking on the ship and providing care from afloat and ashore.

³⁰ USAID and OCHA may be able to assist the Navy in identifying appropriate NGOs for each role.

Role 3: Help with onshore care and service delivery

A third potential role for NGOs during HRHCA missions is to help with onshore delivery of care and services. It would most likely be filled by NGOs that are already established in the partner nations and have facilities there. Depending on mission focus, some NGOs may provide medical services ashore and some may be interested in incorporating Navy capabilities into their own train-the-trainer and public health awareness programs. Still other NGOs may be able to facilitate the transportation of patients to and from the hospital ship or the shore facility.

Coordination with NGOs in this role calls on all three sets of resources. Additional personnel with medical expertise can expand the types of services offered ashore. NGOs with local knowledge and networks can help with advance planning and logistics. Finally, coordination with ashore NGOs can also be considered part of training for disaster response missions since ashore NGOs usually participate in disaster relief efforts.

Role 4: Help with after-visit followup

A final role suggested for NGOs participating in HCA missions is to help with followup care after the visit (or mission). As part of HRHCA missions, visiting physicians usually conduct a variety of surgical procedures on patients, many of whom need to be monitored closely during the recovery period to ensure that complications do not arise or, if they do, to ensure that they are addressed promptly. Followup care may also be needed if mission doctors diagnose chronic ailments that require long courses of treatment. In these cases, required followup must be provided by local medical practitioners.

The NGO resource that is most obviously relevant for this role is medical expertise, but experience is equally important: knowledge of local health institutions, customs, and patients also comes into play.

Summary

In this section, we proposed that NGOs have resources that, when combined with Navy resources, can improve the effectiveness of HRHCA missions. These synergistic resources include not only personnel resources that can broaden the scope and reach of the missions, but also experience and expertise that can be leveraged to decrease the likelihood that the missions have unintended negative consequences and increase the likelihood that they have longer term positive effects. We also identified four potential ways that NGOs can participate in HRHCA missions and discussed which resources are particularly relevant for each role.

Such systematic thinking about why to work with NGOs and the wide variety of ways they can contribute represents one step in the development of a framework for Navy-NGO coordination. In particular, coordination procedures should include explicit identification of the NGO resources that will be most valuable on the mission and the roles that NGOs can play to make those resources available. To do this effectively, however, Navy planners must be able to identify which NGOs in each host nation have the key resources and are capable of filling the desired roles.

The NGO community in the context of HRHCA missions

To fully leverage NGO resources, Navy planners must be knowledgeable of the range of those resources and the types of organizations in which they reside. Planners must develop an understanding of the different NGOs' approaches to providing assistance and their attitudes toward working with the military. In particular, as the Navy begins to develop procedures for working with NGOs on HRHCA missions, it is important for planners to learn the range of NGOs' views regarding the missions and how they fit into the wider world of nonmilitary humanitarian assistance and development activities.

Here, we identify institutional differences within the NGO community that are relevant for HRHCA missions and discuss the implications of these differences for finding common ground between the Navy and NGOs. Using data collected during interviews and conference participation, we then identify and discuss barriers to Navy-NGO coordination. All these factors are elements of the second part of our proposed framework for working with NGOs to achieve the strategic and operational objectives of sea-based HRHCA missions.

The big picture

Throughout this paper, we have used the term *nongovernmental organization* (NGO) without providing an explicit definition of the types of institutions to which this label applies. In general, an NGO is any legally constituted nonprofit organization that is independent of government control.³¹ For purposes of this study, however, we

³¹ The 2007-2008 Yearbook of International Organizations has profiles on 25,000 NGOs that operate in more than one country and are active in "every field of human endeavor." Several million more NGOs are estimated to be operating only within their countries of origin [20].

adopt the definition provided in [21], which bounds the NGO community to only those agencies engaged in certain activities:

The term NGO refers to a private, self-governing, not-for-profit organization dedicated to alleviating human suffering; and/or promoting education, health care, economic development, environmental protection, human rights, and conflict resolution; and/or encouraging the establishment of democratic institutions and civil society.

Even under this more focused definition, there is a still very large number of NGOs. According to [22], in 2003, there were about 3,500 international NGOs providing both development and relief aid in poor countries. The NGO community is dominated, however, by a few large organizations. According to [22], the major international players are: CARE, Catholic Relief Services (CRS), Médecins Sans Frontières (MSF), Oxfam, Save the Children, and World Vision. Among this group, CARE, CRS, Save the Children, and World Vision receive the largest amounts of funding from the U.S. government: in 2000, these four NGOs received 25 percent of the \$2.5 billion of U.S. government funding for relief and development aid; the remaining 75 percent was spread across approximately 400 smaller NGOs. Looking beyond the United States, [23] notes that about 95 percent of all relief work is provided by just 35 to 40 large American and European NGOs.

NGO heterogeneity

The NGO community is heterogeneous, and the organizations it comprises differ in a variety of ways. To help BUMED and other Navy planners better understand the resources and institutional constraints of NGOs, we identified five key dimensions along which NGOs can differ and that may affect NGOs' views on coordinating with the Navy on sea-based HRHCA missions:

- Adherence to humanitarian principles
- Type of aid provided
- Organizational structures
- Funding

- General views on working with the military.

Because there are so many ways that NGOs can differ, we make no attempt to categorize them along any particular dimension or set of dimensions. Indeed, according to [22], “Attempts at producing a typology to describe the NGO ‘community’ have...tended to exaggerate philosophical differences, while downplaying basic practical similarities.”

Adherence to humanitarian principles

According to U.N. General Assembly Resolution 46/182 [24], humanitarian assistance must be provided in accordance with the following basic principles:

- *Humanity* refers to alleviation of suffering, protection of life, and ensuring the respect for the human being.
- *Impartiality* means that aid will be delivered to all who are suffering; the aid community should respond appropriately to all in need.
- *Neutrality* signifies that humanitarian actors will not take sides in controversies or hostilities based on political, racial, religious, or ideological identity.

Not all NGOs subscribe to these principles, and those that do may have different interpretations of the types of activities that are permissible within their bounds. In general, we expect that an NGO’s willingness to work with the Navy on an HRHCA mission would be negatively correlated with its adherence to the humanitarian principles. This is especially true if HRHCA missions are seen as “hearts and minds” campaigns that don’t meet the criteria of neutrality and impartiality [23].³² We discuss this issue in more detail in the subsection on strategic barriers to coordination.

³² The NGO’s view of the principle of neutrality can apply to the entire government, not just the military. See [22] for a full discussion of NGOs’ views toward relationships with governments.

Type of aid provided

There is substantial variation in the types of aid NGOs provide. We identified two key aid distinctions that are especially important for understanding Navy-NGO coordination for HRHCA missions:

- Humanitarian assistance vs. other
- Direct medical services vs. general health services.

Humanitarian assistance vs. other

The widely accepted OCHA definition of humanitarian assistance (HA) points out the distinction between HA and other activities:

HA is aid that seeks to save lives and alleviate suffering of a crisis-affected population. HA must be provided in accordance with the basic humanitarian principles of humanity, impartiality and neutrality. [25]

Thus, by implication, “other” is assistance that is given in non-crisis situations and/or may be delivered without regard to the basic humanitarian principles. Examples of “other” activities include HRHCA, by definition, as well as long-term development assistance.

NGOs differ in the extent to which they are focused on HA or other types of aid: some focus primarily on one or the other, and most do both [20, 23]. In fact, according to [22], very few NGOs identify themselves exclusively as HA, or relief, organizations. Moreover, even identifying NGOs that primarily fall into one category or the other is difficult because most NGOs identify their aid programs by sector (e.g., water and sanitation or education) rather than by the context in which the aid is delivered [22].³³

Nonetheless, understanding the distinction for any given situation is important. At a 2005 workshop on “Humanitarian Roles in Insecure Environments,” civilian and military participants identified lack of clarity on this aid distinction as an obstacle for military-NGO dia-

³³ An exception to this rule is CARE USA, which began to report its expenses in “emergency,” “rehabilitation,” and “development” work in 1998 [22].

logue in crisis settings; we believe it applies in the HRHCA setting as well. The workshop report summarized participants' views as follows [26]:

An important operational weakness that was immediately recognized is the need for a clear definition of roles for the various actors involved as well as a clear definition of "humanitarian assistance" (as opposed to humanitarian relief, development, etc.). Many noted that "such definitions are critical if we are to have a comprehensive understanding of who is doing what, how, and for what reasons."

For the purposes of this study, it is important for Navy planners to understand the extent to which an NGO's HA focus affects its willingness to participate in HRHCA missions. Specifically, an NGO that sees itself primarily as a provider of HA may be less willing to coordinate with the Navy on HRHCA missions because they are not conducted in response to crises and they may not be seen as consistent with the basic humanitarian principles. As a result, the Navy may find that the NGOs that are willing and able to participate in HRHCA missions may not be the same NGOs that the Navy will need to work with in HA/DR missions. In this case, the Navy may consider seeking other ways to plan and practice with HA-focused NGOs, such as conducting tabletop exercises and creating draft memoranda of understanding (MOUs) in anticipation of collaboration in a future crisis.

Direct medical services vs. general health services

For HRHCA missions, there are important distinctions between NGOs that provide direct medical services vs. general health services. The distinctions could have implications for the roles of NGOs in the missions.³⁴

³⁴ This distinction represents CNA's analysis and its opinion of the useful and relevant distinctions between NGOs for BUMED. These are not universally recognized distinctions and they are not applicable to or relevant for all NGOs. According to [23], however, typical NGO sector groupings include food, water and sanitation, shelter, public health and medical, human rights/protection, education, agriculture, gender issues, and de-mining.

Some NGOs focus on providing general health services. These NGOs specialize in activities related to improving health services in the partner nation and increasing public awareness of health-related issues (such as hand sanitation and boiling water to make it potable). These programs are frequently run by multidisciplinary NGOs and are staffed by a mix of public health, development, and medical professionals. The National Societies of Red Cross and Red Crescent and Oxfam are examples of well-known NGOs that focus on health-related issues. In general, the NGOs that focus on health-related issues do not have the capability to conduct medical diagnosis or to provide medical treatment.

Other NGOs focus on providing direct medical services. They specialize in providing direct medical diagnosis and treatment to people in need. The medical-focused NGOs comprise specialized medical professionals, such as surgeons, specialized physicians, and general medicine practitioners. A well-known example of an NGO that focuses on medical-related issues is Operation Smile. In general, NGOs that focus on providing medical services do not focus on improving the long-term health sector capacity.

The role of an NGO in HRHCA missions can vary depending on its mission focus. NGOs that focus primarily on health-related issues could execute responsibilities relating to public health, such as water treatment or sanitation facilities, and build awareness of critical health issues in the community, such as malaria prevention techniques. NGOs that focus mostly on medical-related issues could assist with patient screening, diagnosis, surgery, and followup care. Medical-focused NGOs could work either ashore or afloat, and, while health-focused NGOs could provide ship-riders, most of their work would probably be ashore, unless they provided a training/education session on the Navy ship. The different mission sets lead the NGOs to have diverse areas of focus and expertise, which enable them to coordinate with the Navy in different ways.

Organizational structures

NGOs have different organizational structures, and this can have an impact on the way they are able to work with the Navy. In particular, NGOs have various models for staffing their organizations and for

providing services. Some models lend themselves more easily to participation in HRHCA missions.

Staffing structures

The extent to which NGOs rely on volunteer personnel varies significantly: Some are primarily volunteer-based organizations, while others are mainly staff-based.³⁵ The role of NGOs in HRHCA missions could depend on the personnel systems of the NGOs.

NGOs with paid staffers may be better able to respond to Navy requests for specific personnel, to guarantee that they can fill billets, and to maintain constant levels of participation throughout a mission. However, paid staff members are typically fully engaged in their own projects and are unlikely to be released to support an ad hoc mission. Volunteer-based NGOs could need more flexibility and longer lead time to coordinate their volunteers, but the volunteer arrangement is better suited to the occasional nature of the mission. NGOs with either personnel system can participate in all aspects of HRHCA mission, but if the Navy would like to use NGO personnel to decrement or offset its medical personnel requirements, planners must understand the differences between and constraints of the NGO personnel systems.

Mission approach to service provision

There are, of course, many approaches to service provision. Here we highlight the fact that one approach is especially consistent with the HRHCA mission approach: Some U.S.-based NGOs conduct episodic missions in developing countries to provide medical care and training to underserved populations. Examples of NGOs that use this model are those that have participated in the three recent sea-based HRHCA missions: Project HOPE, Operation Smile, and Aloha Medical Mission. All three of these organizations staff their missions mainly with volunteers.

³⁵ Based on one estimate, about one-quarter of personnel working for international NGOs are volunteers [27].

Given their past participation on HRHCA missions, these organizations are well known to the Navy. It is important, however, for the Navy to be aware that these NGOs are not representative of the broader NGO community. Most NGOs do not employ a mission approach; rather, they focus on ongoing, permanently located projects in specific communities or regions. In fact, in addition to conducting medical and training missions, Project HOPE, Operation Smile, and Aloha Medical Mission all run permanent, in-country programs.

Funding

NGOs have four basic funding sources: private donors, foundations, corporations, and governments. Most NGOs get some funding from all four sources, but the total and relative amounts vary, as does the effect their donors can have on their work. We identify three aspects of funding that might affect an NGO's ability to coordinate with the Navy on an HRHCA mission.

Reliability, level, and timing

Some NGOs have more reliable streams of revenue than other NGOs and can predict their funding levels further into the future. For example, large, well-established NGOs that regularly receive money from foundations, corporations, or governments tend to have more reliable streams of revenue than smaller NGOs that are more dependent on the donations of individuals and groups. In particular, the latter group of NGOs is more susceptible to economic downturns, "donor fatigue," and donor loss of interest.

At any given time, an NGO's ability to participate in an activity or project will depend on its overall level of funding. Smaller NGOs with narrower mandates are less likely to have extra resources available for participation in an HRHCA mission.

Timing of funding also matters. NGOs that focus on providing humanitarian assistance as part of crisis response may have uneven funding streams because they receive most of their funding only when disaster strikes. NGOs with this type of funding may have less scope for participating in HRHCA activities.

Conditionality

Many NGOs face constraints that are placed on them by donors. Some donors earmark their donations for specific projects or activities, which may limit funding availability for NGO participation in HRHCA missions. In particular, according to [23], a fundamental constraint on the ability of NGOs to contribute to after-action assessments or participate in exercises is lack of funding for training and travel for such purposes.

In addition, a recent trend in government funding is a movement toward project-based grants and earmarked contributions to the U.N. This has resulted in greater donor involvement in project and program design because governments impose greater pressure for accountability to donor-defined performance measures [22].

Acceptance of/reliance on government funding

NGOs vary in the extent to which they accept and rely on government funding. Some NGOs believe that accepting government funds violates the principle of neutrality, while others accept government funding as simply a means to execute their own missions and organizational agenda. The extent to which an NGO is unwilling to accept government funding for fear of jeopardizing its neutrality may be an indicator of its willingness to participate on HRHCA missions.

According to [22], most of the major U.S. NGOs rely heavily on government funding. For example, CARE and Save the Children receive nearly half of their funding from the U.S. government, and the International Rescue Committee is nearly 70 percent publicly funded. The exceptions among large U.S. NGOs are the faith-based organizations: World Vision and CRS are much less reliant on government funding. The large European NGOs also rely less on government funding and more on private donations. Both Oxfam GB and MSF receive more than 70 percent of their funding from private parties.

NGOs that participate in sea-based HRHCA missions could need additional support to meet organizational goals to advertise the mission, satisfy donors, and maintain a stream of revenue. An example of additional support may be that the NGO might want to partici-

pate in certain public relations events, or the NGO might want daily access to the internet in order to post photographs and updates from the mission.

Attitudes toward working with the military

NGOs differ significantly in their attitudes toward working with the military, and this variation is based on several of the factors already discussed. Clearly, NGOs that look unfavorably on working with the military in general will be less likely to participate on HRHCA missions.

NGOs that are primarily engaged in HA activities and that strictly adhere to the humanitarian principles tend to be less inclined than other NGOs to work with the military. This is typically understood to be both a matter of security and a matter of principle. Many NGOs believe that their security in conflict environments is based on their reputations for neutrality and impartiality. They are, thus, concerned that any association with the military may jeopardize the safety of their field personnel. For these organizations, interaction with the military should occur only under exceptional circumstances of insecurity or inaccessibility [28]. At a more fundamental level, [26] poses the question, "Why should there be common operations or training exercises when the ultimate objectives of our organizations are different?"

Some NGOs, however, take a more pragmatic view. The fact that the military is increasingly engaged in multiple kinds of stability operations means that the military and NGOs will increasingly be operating in the same space. This suggests a minimum need for cooperation and coordination, including increased education and communication between the military and NGOs prior to future deployments [29]. To this end, some NGOs are seeking to improve cooperation with the military. According to [20], CARE and World Vision have hired former military officers to facilitate better cooperation.

Finally, some NGOs see no conflict in working with the military and are happy to avail themselves of the resources it has to offer. These are (1) organizations that do not perceive that an association with the military poses a threat to the safety of their field personnel

and/or (2) organizations that see alignment between their organizational objectives and those of the military mission.

Implications of NGO heterogeneity

NGO heterogeneity has important implications for synergistic Navy-NGO coordination. The dimensions of heterogeneity described earlier can be summarized as differences in organizational philosophies, objectives, and operational approaches. To make sense of these differences and how they affect both the likelihood that NGOs will participate in HRHCA missions and the resources they bring to the table, Navy planners should think in terms of common ground or areas of overlap:

- **Organizational philosophy:** Shared, or at least compatible, organizational philosophies can be the starting point for any coordinated effort.
- **Objectives:** Even when the Navy and NGOs do not share a common organizational philosophy, they may be able to agree on the main objectives of a particular mission or activity.
- **Operational approach:** Similar operational approaches will facilitate coordination, but different approaches may create opportunities for synergy or complementarity.

Effective Navy-NGO coordination will require some overlap in at least one of these areas; the degree of overlap will vary across NGOs. In a few cases, such as with the NGOs that have consistently participated in the recent HRHCA missions, there is overlap in all three areas. These NGOs have compatible operational models, they have programs that focus on direct care delivery, and their organizational philosophies do not prohibit them from working with the military. We expect that there are also cases in which overlap is not sufficient to make coordination worthwhile for at least one party. The focus area for the Navy should be identifying NGOs that fall in the middle ground—those cases in which the overlap is sufficient, albeit not maximal, to create mutual value in coordinating.

Barriers to NGO participation in sea-based HRHCA missions³⁶

Barriers to NGO participation in Navy HRHCA missions can be found at the strategic, operational, and tactical levels. Strategic-level barriers are philosophical differences on why and how medical and health assistance should be provided to underserved populations. Operational-level barriers, broadly defined, are conflicting approaches to the mission-planning process. And tactical-level barriers include issues confronted day to day while the mission is in progress. Strategic-level barriers, when raised, tend to totally **prohibit** NGO participation on HRHCA missions, while operational- and tactical-level barriers tend to **inhibit** effective participation.

Strategic-level barriers to NGO participation

Strategic-level barriers are most likely to keep an NGO from participating in a mission altogether. Despite the number of strategic-level barriers outlined in this subsection, however, most whose views we heard did not object to the basic notion of a military-led HRHCA mission. As one interviewee summarized, “I would not discourage a mission that is for the benefit of the patient.” Only one organization completely dismissed the notion that the U.S. military should conduct medical missions. The remaining organizations included in the study expressed varying degrees of support for the missions, though almost always followed with a conditional statement that cited one or many strategic barriers.

Conflict with humanitarian principles

A frequently cited concern was the perception that the Navy does not fully appreciate the importance of the humanitarian principles

³⁶ This subsection draws primarily from our interviews and conference participation with nonmilitary personnel, especially representatives from NGOs and IOs, but also those from academic institutions and the U.S. government. In general, we present what seemed to be the consensus perspective of the people whose views we heard. In some cases, however, we draw attention to differences of opinion across organizations.

to NGOs' security and livelihood. Most important, the NGOs struggle with how they will be perceived globally if they are known to work with the U.S. military. Even though HRHCA missions are typically not conducted in insecure environments, they receive significant publicity and, therefore, have the potential to affect an organization's reputation beyond the regions in which they occur.

Terminology

Humanitarian. Many in the NGO community view a military's use of the word *humanitarian* as a threat to NGO personnel safety and credibility in the communities where they operate. As one interviewee noted, with wider acceptance of the humanitarian principles, humanitarianism has come to connote impartiality and neutrality. Once militaries begin to publicize their actions as humanitarian, the word loses meaning. When the word has lost meaning, the credibility of humanitarian organizations may also be questioned.

Another organization explained its dislike for the military's use of the word in this way, "A medical mission alone does not qualify an act as humanitarian, so the term should not be used." The word should be used only when an act fully encompasses the definition. Militaries inherently cannot be neutral, so they should not use the word *humanitarian*. Yet another institution used the goals of HRHCA missions to discredit the military's use of the word: "If the goals of the mission are to make contacts and provide assistance, then it cannot be called a humanitarian mission."

Taking all of these points together, the perceived oxymoron *military-sponsored humanitarian assistance* can make NGOs skeptical of the true intentions of the HRHCA mission and disinclined to participate.

Partnership. The word *partnership* implies collusion. An impartial and neutral organization that is a humanitarian organization cannot be seen to collude with partial entities, such as a military. A military is a political tool, and a partnership with a political tool includes both sides of the partnership in the political agenda. To avoid any misinterpretation, humanitarian organizations can participate in a military event but will not partner with a military. For these reasons, the

Guidelines for Relations Between U.S. Armed Forces and Non-Governmental Humanitarian Organizations in Hostile or Potentially Hostile Environments, coauthored by the United States Institute for Peace (USIP), InterAction, and DOD, states that “U.S. Armed Forces should not describe (NGOs) as ‘partners’” [21].³⁷

Force multiplier. Civilian organizations strongly object to being called a force multiplier. The USIP/InterAction/DOD Guidelines state that “U.S. Armed Forces should not describe (NGOs) as ‘force multipliers’ of the military, or in any fashion that could compromise their independence and their goal to be perceived by the population as independent” [21]. Thus, the term *force multiplier* is seen, at minimum, to imply a loss of organizational identity and incorporation into a greater military body. Some further interpret it to imply the exploitation of the organization or individual for the needs of the military mission.

This term is also objectionable on other grounds. Civilian personnel are professionals in their own fields and are independent of the military. Civilians value their independence from the military, and many will only participate in Navy HRHCA missions if a certain semblance of their independence is maintained. Furthermore, NGOs believe that they possess a skill set (frequently acquired through extensive field experience) that is unique to humanitarian assistance and can enhance the impact of the mission. The term *force multiplier* assumes that NGO capabilities enhance skills already within the military.

Inappropriate approach to the provision of medical and health assistance

Although most organizations interviewed were not opposed to Navy HRHCA missions (and might even participate if they were given enough lead time before the ship arrived at a port close to a sustained project), the same organizations stated that it was not clear the mission could make a long-term sustained impact and that it might even cause more damage than good. Both issues are causes

³⁷ These same concerns apply to the words *cooperate* and *collaborate*. The preferred phrase is *coordinate with*.

for concern in the NGO community and can keep organizations from participating.

Many cited the need to see a long-term plan for sustainability of the project in the community. At a minimum, NGOs need to see that the mission will coordinate with the local health ministry, increase local medical capacity, and target the most in need. The provision of advanced medical care, alone, is not sustainable. It does little good for a host-country doctor to practice medical care in First World facilities. This is not their work environment.

Furthermore, most NGO health programs do not provide disease diagnosis and treatment, but rather focus on public health and train-the-trainer courses. Many see the Navy approach to providing medical assistance as “out of reach and out of touch” with the NGO approach to health care. The lack of a sustainability plan portrays “the Navy mission as a charity act.” NGOs need to be convinced that the mission is otherwise before they consider participating. “A brochure with goals and objectives of the mission would be helpful,” mentioned one NGO representative.

With a clear idea of the intentions of an HRHCA mission, many organizations indicated that they would be open to discussing participating in an HRHCA mission or connecting the capabilities of a mission to a long-term project on the ground. One interviewee, however, cautioned, “Don’t try to connect a [HRHCA] mission to any macro indicator of a country’s development. Even the development community doesn’t try that.” Similarly, another warned, “Don’t try to act like a new kid on the development block, because the military is not.”

Others went beyond requesting the military to be clear about the immediate and long-term capabilities of an HRHCA mission. HRHCA missions also need to transparently demonstrate that steps have been taken to guard against the negative consequences of providing medical care to foreign populations. A catch phrase in the NGO health care community for an HRHCA type of mission is “drive-by medicine,” which can cause as many problems as it cures. Simply put, NGOs want to ensure that HRHCA missions don’t undercut the medical system it hopes to help.

The most common problems that come with drive-by medicine include undercutting local private medical practices, providing drug regimens that cannot be sustained by the local clinics (which then has the effect of discrediting the capability of the local health care in the eyes of the local population), and providing care that may need followup attention, but medical records are not left with any local medical provider.

A plan that does not transparently address how these issues will be mitigated can prompt many in the NGO community to distance themselves from a Navy HCA mission.³⁸ To help solve these issues, one NGO representative advised that HRHCA missions be more systematic in their approach to medical care and conduct followup missions. A representative from a different organization cautioned that it is important to have a well thought out approach to medical service and to mitigate risk when possible, because the “message is in your methods.”³⁹

Inappropriate role for a military institution

Consistent with concerns about the use of the word humanitarian to described military medical and health assistance programs, some NGOs question whether HRHCA is an appropriate activity for the military. The argument is as follows: militaries should not provide any semblance of “humanitarian” assistance because such assistance must be neutral and militaries are inherently never neutral. In extreme cases, militaries are needed to respond to large disasters, such as the 2004 Southeast Asian tsunami. Yet, these extreme cases are rare. As one person said, “the market for large scale disaster assistance is very small.” A hospital ship is useful only during the first few days after a disaster, when trauma care is needed. In addition, an appropriate and welcome role that militaries can play is logistical support, but again only in disaster relief situations.

³⁸ Interviews with Navy personnel indicated that they are aware of many of these issues and have taken them into consideration when planning for future missions.

³⁹ These issues have been extensively addressed in other forums. For example, see [29] and [23].

A variant on this theme is that there is overlap and lack of coordination with other U.S. government programs. In particular, the role of USAID as the lead U.S. government agency for development and humanitarian activities was frequently emphasized. In some cases, it was argued that USAID is the only U.S. government agency that should be engaged in these activities. In other cases, the emphasis was on the need for better interagency coordination between the DOD, DOS, and USAID, especially in the early strategic planning phases.

Lack of clarity as to why the U.S. Navy wants NGO support

The NGOs that have and have not participated on past HCA missions provided varying and unclear answers as to why the U.S. Navy would seek civilian participation. A theme expressed throughout the interviews was that NGOs would be more open to working with the missions if the Navy's reasons for conducting them and for including other institutions were transparent. One interviewee said, "What's the objective for encouraging NGO participation? All follows from that." An NGO representative who has participated on past HFHCA missions was unsure of the primary purpose of the mission—primary care on land or surgery on ship, or both? The Navy's lack of a unified approach to explaining why (why carry out the mission, why include NGOs and IOs) leaves a sense of confusion and distrust.

The institutions interviewed provided both altruistic and self-interested incentives for the Navy to encourage NGO participation on HRHCA missions. Responses included the following:

- The military wants to train for disaster relief.
- The military wants to contribute to the long-term development of a country by bringing together all resources and making a bigger impact.
- NGOs and the military working side by side will treat more patients.
- NGOs make the military look less intimidating, which helps improve their reputation abroad.

- NGOs can provide manpower and resources that the military can take credit for.

Without a clear statement on why the Navy wants to include NGOs on HRHCA missions, the civilian community is left to speculate. Much of the negative speculation could be preempted with a clear statement that outlines the benefits for both parties to participate in Navy HRHCA missions.

Site selection and needs assessments

A concern of some NGOs is the U.S. military's strategic approach to choosing the sites that receive medical support. Some NGO personnel assumed that the Navy chose site visits according to political objectives and provided services according to the Navy's capabilities. At times, political objectives and the Navy's inherent capabilities have guided HRHCA missions to the most-in-need patients. In other instances, however, the ship has serviced and spent large sums of money on populations that already have access to adequate medical systems. This strategic barrier has led to a number of NGO perceived operational barriers to military-civilian coordination that will be addressed in the following subsection.

Operational-level barriers to NGO participation

Operational barriers are found mostly in the planning stages of an HRHCA mission, but also in the approach to how an operation is conducted, and in the organizational structures of the multiple institutions involved. Operational barriers are usually resolvable and will not keep an organization from participating in a mission. However, partially unresolved or altogether ignored operational barriers can dissuade NGOs from either participating or returning for a second mission.

Site selection and needs assessments

NGO personnel were frustrated to see too many preidentified surgery patients turned away because of miscommunication between the Navy and the partner nation as to how many patients the ship could service. If the ship intends to do approximately 200 surgeries, the host-country ministry of health should identify 250 to 300 sur-

gery cases and manage expectations by making sure every patient knows that he or she may not be chosen for surgery.

In addition, NGO personnel were frustrated that on many occasions the ship did not treat the population most in need. The problem arose not only with patients preidentified for surgery but also with patients who arrived to receive general medical services. The problem was most apparent when the ship chose sites inside large urban areas with well-established health systems. At these locations, not only were many patients not the most in need, but large crowds formed that were tough to manage, and the medics had to leave untreated patients waiting at the end of the day. Furthermore, poor crowd control meant that NGO volunteers saw fewer patients, which further frustrated the volunteers. NGOs attributed the lack of onsite organization to poor communication between the Navy planners and local entities.

Several interviewees recommended that the Navy always use USAID and/or the partner nation ministry of health (when it exists) to identify sites and conduct needs assessments. In instances when the ship visits remote regions not serviced by a health ministry or regions affected by complex emergencies, it was suggested that the Navy work through NGOs or the country health cluster.⁴⁰

NGO solicitation

Some organizations perceived that the Navy's approach to NGO solicitation was too ad hoc. For example, two organizations complained of being solicited by multiple military contacts at the same time about different initiatives. Keeping track of such solicitations can be difficult even for large NGOs, but interviewees cautioned that the Navy should be especially careful not to overwhelm either smaller, in-country offices of larger NGOs or local NGOs.

⁴⁰ Country health clusters are composed of health experts from the host government, not-for-profit and private development programs that maintain or sponsor health projects in the country. The clusters generally meet once a month to coordinate efforts and/or prevent project overlap. The cluster concept was introduced in the past few years and may not be established in all developing countries. Clusters can exist for multiple functions, such as health and livelihoods.

To improve or systematize the Navy's (or the COCOM's) approach to inviting NGO participation, many organizations emphasized the role of USAID as a primary liaison between the Navy and NGOs. OCHA was also identified as a key connection point for military coordination with NGOs overseas.

OCHA's mission is to mobilize and coordinate humanitarian action by national and international actors in order to alleviate suffering in emergencies and disasters and *to promote preparedness and prevention*. In support of this mission, OCHA's Civil-Military Coordination Section (CMCS) is the focal point for civil-military coordination in the U.N. system. The CMCS provides civil-military services, including "common training, support for exercises, internationally agreed guidelines and operational capabilities" [30]. CMCS is responsible for coordinating between civilian and military actors in humanitarian emergencies, while emphasizing coexistence, cooperation, and shared responsibility. While CMCS is called on primarily in times of crisis, its civil-military training programs, exercises and operations, and coordination guidelines also support OCHA's mandate for promoting preparedness and prevention of crises.⁴¹

OCHA has representatives located in United Nations Development Program (UNDP) regional offices around the world. These representatives can facilitate coordination between Navy leadership (including COCOMs) and NGOs. The Navy could contact regional officers to gather information, identify NGOs, and/or connect with relevant government officials. According to discussions with OCHA personnel, the U.S. military did not contact them for the recent sea-based HRHCA missions.

Scheduling

The NGO volunteers who go aboard the ship need to buy tickets and take vacation well in advance of the mission, which poses significant problems when the Navy changes the dates of a port visit. Tickets to remote locations are expensive, difficult to get, and often

⁴¹ For more information, see [31] and [32].

not refundable.⁴² Also, the issue with vacation time is especially problematic for the volunteer nurses and physicians who cannot reschedule time away from their practices at the last minute. NGO ship-riders need to finalize mission plans 4 to 6 months in advance. For example, a surgeon and anesthesiologist from Aloha Medical Mission had to drop out of *Peleliu*'s visit to the Philippines due to a last-minute date change.

On the same note, shore-based NGOs also request 6 months' notice of the Navy ship's capabilities and dates in port. That time is needed for these in-country organizations to determine whether the Navy's assets could be incorporated into a long-term project already established in the region. Also, the in-country offices need this time to make sure the Navy mission will not replicate another public health or medical event planned for the same dates.

Personal relationships

NGO personnel who participated on both the 2006 *Mercy* and 2007 *Peleliu* missions indicated that military-NGO relations aboard ship were heavily dependent on the Commodore's approach to NGO integration. When the Commodore encouraged NGO participation in planning sessions and daily mission briefs aboard ship, military-NGO relations ran smoothly. In contrast, a Commodore's choice to exclude NGO personnel from such decisions while the ship is en route can spoil relations. A consistent (across organizations and deployments) and open approach to dealing with NGO personnel aboard ship would greatly facilitate relations.

NGO funding streams

Some organizations may be inhibited from participating in military-led HRHCA missions due to concerns that their donor base may disapprove. Essentially, NGOs need to spend money within the bounds of their donors' and funders' expectations. In other cases, an organization may simply not have the funds to devote to a Navy HRHCA mission. In particular, the NGOs that have participated on

⁴² Navy interviewees did mention that there is an effort to amend 10USC401 to allow the military to pay NGO volunteers' travel expenses.

missions as ship-riders indicated that funding for travel to embarkation points is not covered in their budgets and places a significant financial burden on their volunteers who are already donating their time. More generally, USAID stated that the organizations they fund could not use USAID funds to support a Navy HRHCA mission.

HRHCA mission platform—white hull or grey hull

Only the IFRC and Operation Smile cited a grey hull color (indicating war ships) as a factor in deciding whether to participate in an HRHCA mission. Personnel at the IFRC headquarters in Geneva, Switzerland, thought it very important that a medical mission be conducted from a hospital ship (which is painted white and marked with a large red cross) protected under the Geneva Conventions. The underlying argument was that a ship providing humanitarian services must clearly not have or be perceived to have any military capabilities. The Operation Smile Chief Medical Officer believed the symbolism of the hospital was very significant.

Still, even IFRC headquarters recognized that IFRC country societies may not distinguish between a white- or grey-hulled ship. And all others said that, symbolically, there was no difference between the two ships. The prevailing point of view was that a white-hulled ship was still a U.S. military asset and carried the image associated with the U.S. military, whether its intentions were hostile or not. Regardless of hull color, the participating organizations and partner nation populace know that the ship means U.S. military. “Either way it’s a U.S. military engagement.”

Contrary to expectations, NGO personnel also indicated that the hospital ships are less suitable than amphibious assault ships to the transportation and berthing demands of HRHCA missions. NGO personnel who worked aboard both a white hull (*Mercy* in 2006) and a grey hull (*Peleliu* in 2007) preferred the living and working environment aboard the grey hull. First, the living quarters aboard *Peleliu* were considered more comfortable because there are more officers’ quarters available for NGO personnel. In contrast, many NGO volunteers were placed in enlisted berthing on *Mercy*. This living arrangement was especially difficult for surgeons, who were unable to get adequate rest in large shared rooms. Second, the smaller size of *Peleliu* meant there was a better opportunity to get to know

other shipmates, which facilitated military-NGO relations. Some NGO personnel complained that USNS *Mercy* was too large and unmanageable. Finally, the lift capability of *Peleliu* is far better than that of *Mercy*, which allows for a greater number of medics on the ground and more time with the patients. NGO personnel did mention that the operating room facilities aboard *Mercy* are superior, but, in general, the *Peleliu* was the preferred platform for HRHCA missions.

Tactical-level barriers to NGO coordination

For those NGOs that have significant experience with Navy HRHCA missions, the study revealed that any mix of tactical barriers can also deter NGOs from participating or can prompt them to leave the mission early. Our interviews with both the NGO and Navy personnel, however, signaled that significant progress was being made at overcoming barriers at the tactical level.

Credentialing

Guidance on credentialing was conflicting, according to some NGO representatives. In one case, Aloha Medical Mission (AMM) personnel were told that they could be in charge of credentialing their medical volunteers. After completing the credentialing process, AMM was told that the Navy rescinded its previous statement and said that it would have to credential the doctors itself. AMM protested and the Navy backed down. Even still, the Navy demanded medical professionals' credentials once aboard ship, which caused significant headaches. Ultimately, the NGO's anesthesiologists were not allowed to practice.

Beyond complications with NGOs, interviewees expressed concern that foreign military surgeons have also been invited aboard ship, but then not permitted to perform surgery due to lack of accepted credentials. These foreign military personnel reportedly expressed their discontent to their NGO surgeon counterparts. To avoid confusion, NGO representatives said that the Navy should make clear from the outset that all medical professionals will need to provide credentials or they will not work.

Ship-to-shore transportation

A tactical barrier unique to the hospital ships is their poor lift capability. Specifically, on the 2006 *Mercy* mission, NGO volunteers were frustrated that they could not work ashore regularly. They felt deceived or were simply unaware of what the mission entailed. Those same volunteers who also worked aboard *Peleliu* said that the ship-to-shore transportation ran much more smoothly. Still, a lot of valuable time is lost during the commute that entails going from ship to shore via helicopter or boat and sometimes bus. Interviews with both NGO and Navy personnel indicate that much has been done to help alleviate this problem. Some interviewees from medical-focused NGOs mentioned that working aboard ship is about making tradeoffs between onshore efficiency and onboard capabilities. One person said frankly that the ship limited the scope of the mission, but he was there for the surgical facilities.

Military uniforms

The NGO and IO organizations had contrasting opinions on the preferred military dress code. The USIP/InterAction/DOD guidelines on civilian-military relations during humanitarian operations in hostile environments clearly state that military personnel should always be uniformed to distinguish them from NGO workers [21]. As with many other topics on civilian-military relations outside hostile and crisis environments, however, there is a lack of policy guidelines on military uniforms. Some interviewees said that the military should wear civilian clothes to look less intimidating. Others asked that the military wear uniforms to clearly distinguish themselves from the civilian care providers. Ultimately, each opinion probably reflects the environment in which the respondent has had the most contact with military personnel. The ideal dress code is similarly dependent on the history of civilian-military affairs in each respective region.

Patient followup care

One organization was notified by in-country contacts that, in a group of patients who had received cataract surgery, many patients had loose lenses and needed followup care. However, the Navy medics had not left patient records with any host country institu-

tion. The organization was bothered to learn that the mission had not left all patient records with a partner nation medical provider so that appropriate followup care could be provided if needed.

NGO-military communication aboard ship

NGO personnel were frustrated because there was no obvious person with whom they should establish liaison when a question arose while aboard ship. NGO managers felt uncomfortable consistently having to seek out different people, including the captain. Having one specific NGO liaison officer would keep volunteers from bothering multiple contacts and save time on both sides of the coin.

Minor surgeries

NGOs believed that many more surgeries could be performed if minor surgeries—"lumps and bumps"—were conducted ashore in temporary surgical tents. These minor surgeries could be conducted ashore with little difficulty, which would open up time and space to conduct more difficult surgery in the ORs aboard ship.

Visas

NGO volunteers said that they have been given conflicting information on visa procurement. Sometimes the Navy has said that it will provide visas, but other times it will not. If the Navy will not provide visas, it should be made clear from the beginning of the planning process to ensure that NGO volunteers have sufficient time to apply for and receive the necessary visas.

Summary

In this section, we described how widely NGOs vary in terms their organizational philosophies, objectives, and operational approaches. In its efforts to identify opportunities for synergistic coordination, we proposed that the Navy should look for NGOs with which they share common ground in at least one of these three areas. In addition, we described the main strategic, operational, and tactical barriers to Navy-NGO coordination that surfaced during our interviews and at conferences.

Highlighting the importance of commonalities, or overlap, in these basic organizational characteristics represents a second step in the development of a framework for Navy-NGO coordination. Identifying key barriers to coordination was the final step.

Conclusion

To help BUMED's M5 make policy recommendations for planning and manning the medical element of sea-based HRHCA missions, CNA was asked to investigate ways to leverage NGO resources as complements to Navy resources. Our review of high-level guidance and assessments of the 2006 *Mercy* mission, combined with our interviews with Navy and civilian personnel, indicates that there is currently no accepted set of procedures either for conducting sea-based HRHCA missions in general or for coordinating with NGOs to execute them.

To fill the latter gap and fulfill our tasking, this conclusion synthesizes the information and perceptions presented in the previous sections in the form of a conceptual framework for coordinating with NGOs to increase the effectiveness of HRCHA missions. To help with future application of the framework, we then make a series of recommendations regarding ways to overcome strategic and operational barriers to coordination and to increase Navy-NGO resource synergies.

Before presenting the framework, however, we make one recommendation that stands above it: To effectively participate in long-term Navy Medicine strategic planning, including total force and mobilization planning, BUMED and M5 must be given clear guidance from DOD and the Navy on both the purpose of working with NGOs on these missions and the priority placed on staffing for HRHCA missions relative to staffing for the benefits and wartime missions.

Framework for coordinating with NGOs to deliver effective HRHCA

The framework is intended to move the Navy away from thinking about NGO participation as an end in and of itself, and toward

thinking about working with NGOs as a way to enhance the strategic and operational effectiveness of the missions. The framework has four steps that focus on common ground and synergies:

1. Articulate mission objectives
 - Assure friends and allies
 - Train for disaster response
 - Provide care and service to underserved populations
2. Together with NGOs, identify common ground
 - Organizational philosophy
 - Mission objectives
 - Operational approach
3. Decide to coordinate
4. Work out how to coordinate
 - Identify synergistic resources
 - Assign roles
 - Address operational and tactical barriers.

Recommendations

Develop requirements for manpower and personnel

It will be much easier to create a process for integrating embarked NGOs into Navy HRHCA missions if there is a standard process for determining active-duty staffing. Therefore, we recommend placing high priority on the development of Navy medical manpower requirements for HRHCA missions.

We also strongly recommend that NGO medical professionals *not* be expected to systematically offset Navy medical personnel requirements for HRHCA missions. Decrementing, however, has been done successfully on past missions and could be done in the future. Augmenting has also been effective, but planners should consider such variables as ship-to-shore lift capability and host country medical needs when accepting NGO augmenters.

Overcome strategic barriers to create new opportunities for coordination

Established relationships with NGOs should be maintained and strengthened. In addition, we recommend exploring new relationships with other NGOs that may have different resources that enhance the effectiveness of the missions in new ways.

To develop relationships with a wider range of NGOs, we recommend that the Navy work with the COCOMs and DOD to address the strategic barriers cited by these organizations as reasons for not participating in Navy-led HRHCA missions. We specifically recommend addressing three of the most frequently mentioned strategic barriers:

- The Navy should adopt terminology that is consistent with the terminology being used in the broader community of humanitarian assistance providers. Although this sounds like an easy fix, it may actually require some culture change to ensure that the underlying implications of the new terminologies are understood and embraced.
- The Navy and mission planners should be clear about why they are asking for NGO participation. In particular, coordination should be beneficial to both parties; NGO management must see that the military is neither seeking to displace them in their traditional fields of operation nor seeking to use them to achieve primarily political ends.
- Mission planners need to clearly show that HRHCA missions treat the “most in need” and that provision of free care will not undermine existing health care delivery systems.

Overcome operational barriers to improve coordination

To facilitate coordination with embarked NGOs, Navy planners should continue to incorporate lessons learned from previous missions. Many steps are under way to address the primarily operational barriers that inhibit efficient leveraging of NGOs’ resources. Below we provide recommendations regarding the three key barriers:

- **NGO solicitation:** To work more effectively with host nation NGOs, we recommend that mission planners work as closely as possible with USAID. This may require the creation of formal mechanisms or processes for interagency cooperation on HRHCA missions.
- **Scheduling:** Planners should continue to strive to give NGOs as much notice as possible on the mission schedule and any ensuing changes to it. Timely and transparent notifications of schedule changes improve NGO morale and likelihood of participating.
- **Time commitment:** When inviting medical-focused NGOs to embark personnel, the Navy may consider stipulating a minimum time commitment of 10 to 14 days. This will maximize NGOs' medical contributions, as well as allow their personnel to more fully integrate with the ship's military medical component. It will also lighten the burden on ship-board planners who must coordinate personnel each day.
- **Specialty selection:** To establish relationships with medical-focused NGOs, the Navy has accepted embarked personnel regardless of specialty. As these institutional relationships mature, the Navy may consider being more selective to ensure that NGO expertise matches the services being performed. Doing this would make the experiences of NGO personnel more satisfying and, again, make daily coordination of personnel easier.

Make a change in the approach to coordination that may increase synergies

Finally, we make four recommendations that we think will not only help to overcome strategic and operational barriers associated with organizational differences in planning cycles and ways of doing business, but also ultimately increase the impact of sea-based HRHCA missions:

- NGOs should be further integrated into the mission planning process. Early involvement will maximize the extent to which NGOs can contribute to any mission. In addition to

scheduling, NGOs should be consulted on such topics as project selection, site selection, and needs assessment.

- HRHCA planners should seek to work with organizations that have local knowledge and local or regional presence. This is an area in which the Navy has relatively little knowledge and is most likely to benefit from working with NGOs.
- Mission planners should look for opportunities to support ongoing projects being conducted by in-country NGOs. Adding Navy resources to existing, long-term efforts is likely to have a greater and more lasting impact than adding NGO resources to short-term Navy efforts.
- The Navy and the military should approach working with NGOs as a learning opportunity. Everyone acknowledges that the military brings specialized skill as well as unparalleled logistics and lift capability to the HRHCA environment; however, the military is still lacking experience in this arena. NGOs, in contrast, have many years of experience learning how to work in developing countries and with civilian agencies.

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Appendix: Interviews, Conferences, and Review Panel

Informal Interviews

Department of Defense

Office of the Secretary of Defense

- Office of the Under Secretary of Defense for Personnel and Readiness
- Office of the Under Secretary of Defense for Personnel and Readiness, Civilian Personnel Policy
- Office of the Under Secretary of Defense for Personnel and Readiness, Defense Health Affairs
- Office of the Under Secretary of Defense for Policy, Global Security Affairs, Partnership Strategy
- U.S. Navy Liaison to World Health Organization (WHO)

DOD Academic Institutions

- Center for Excellence in Disaster Management and Humanitarian Assistance, Humanitarian Operations Advisor
- Naval Postgraduate School, Center for Stabilization and Reconstruction Studies, Program Coordinator
- The Uniformed Services University of the Health Sciences (USUHS), Center for Disaster and Humanitarian Assistance Medicine (CDHAM), Director of Research

U.S. Navy

- U.S. Pacific Command, Office of Command Surgeon, Medical Theater Security Cooperation
- U.S. Pacific Fleet, Destroyer Squadron 31, Plans Officers and JAG Augment
- U.S. Pacific Fleet, Office of the Fleet Surgeon
- U.S. Pacific Fleet, Policy and Plans Office, Foreign HA/DR Plans

U.S. Government

- U.S. Agency for International Development, Missions in Asia and the Near East, Office of Technical Support, Civil-Military Relations

Nongovernmental Organizations

- Aloha Medical Mission, Overseas Missions, Mission Leader
- CARE USA, Emergency and Humanitarian Assistance Unit
- InterAction, Humanitarian Policy and Practice, Disaster Responses
- Médecins Sans Frontières (MSF), Policy and Advocacy Coordinator
- Mercy Ships, International Operations Center, International Health Care and Programs
- Project HOPE, individual volunteer

International Organizations

- International Federation of Red Cross and Red Crescent Societies (IFRC), Operations Coordination Team
- International Organization for Migration (IOM), Emergency and Post Crisis Division
- U.N. Office for the Coordination of Humanitarian Affairs (OCHA), Emergency Services Branch
- United Nations Development Program (UNDP), Bureau for Crisis Prevention and Recovery, Early Recovery and Cross Cutting Issues Team
- World Health Organization (WHO), Health Action in Crises

Other

- RADM Marsha "Marty" Evans (USN ret.) and former President and CEO American Red Cross

Conferences Attended

- USNS *Comfort* Deployment, Mid-Planning Conference, Mayport, FL, March 2007
- USNS *Comfort* Deployment, After-Action & Lessons Learned Conference, Bethesda, MD, November 2007
- Center for Security and Reconstruction Studies Conference: The U.S. Navy's 2008 Stability and Security Conference, January 2008, Crystal City, VA
- Navy-NGO Coordination Meeting, September 2008, Alexandria, VA

Review Panel

- Roy Brennan, Humanitarian Affairs Expert
- John Christiansen, Program Coordinator, Center for Security and Reconstruction, Naval Postgraduate School
- Sharon McHale, Humanitarian Affairs Expert
- Howard Roy Williams, President & CEO, Center for Humanitarian Cooperation

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